

STATE OF SOUTH DAKOTA
OFFICE OF PROCUREMENT MANAGEMENT
523 EAST CAPITOL AVENUE
PIERRE, SOUTH DAKOTA 57501-3182

Meaningful Use Auditor

PROPOSALS ARE DUE NO LATER THAN 06/14/2017 at 5 PM CDT

RFP #: 963

BUYER: Division of Medical
Services

POC: Mark Close
Mark.Close@state.sd.us

READ CAREFULLY

FIRM NAME: _____ AUTHORIZED SIGNATURE: _____

ADDRESS: _____ TYPE OR PRINT NAME: _____

CITY/STATE: _____ TELEPHONE NO: _____

ZIP (9 DIGIT): _____ FAX NO: _____

FEDERAL TAX ID#: _____ E-MAIL: _____

PRIMARY CONTACT INFORMATION

CONTACT NAME: _____ TELEPHONE NO: _____

FAX NO: _____ E-MAIL: _____

1.0 **GENERAL INFORMATION**

1.1 **PURPOSE OF REQUEST FOR PROPOSAL (RFP)**

This is a request for proposal for a qualified offeror to complete Meaningful Use Stage 2, Modified Stage 2, and Stage 3 audits on the eligible professionals who received an Electronic Health Record Incentive payment from the State of South Dakota. It is estimated that 200 of the eligible professionals who qualify will attest with South Dakota Electronic Health Record Incentive Payment Program with the number decreasing each year as providers reach their maximum allowed Medicaid Electronic Health Record Incentive Payment. Program year 2016 is the last year a provider is able to join the Medicaid Electronic Health Records Incentive Program as a new provider attesting to Adopt, Implement, Upgrade (AIU). As of February 1, 2017, South Dakota has paid incentive payments for Adopt, Implement, Upgrade (AIU) to 391 eligible providers. As of February 1, 2017, South Dakota has paid incentive payments for Meaningful Use (MU) to 507 eligible providers.

The successful offeror will comply with all requirements contained in 42 CFR part 495, Standards for Electronic Health Record Technology Incentive Payment Program. The offeror will be responsible for adherence to the approved Audit Strategy ([Attachment A](#)), conducting the audits, reporting the findings and recommend continuous quality improvement.

1.2 **ISSUING OFFICE AND RFP REFERENCE NUMBER**

The Department of Social Services, Division of Medical Services is the issuing office for this document and all subsequent addenda relating to it, on behalf of the State of South Dakota, Department of Social Services, Division of Medical Services. The reference number for the transaction is RFP #963. Refer to this number on all proposals, correspondence, and documentation relating to the RFP.

Please refer to the Department of Social Services website link <http://dss.sd.gov/keyresources/rfp.aspx> for the RFP, any related questions/answers, changes to schedule of activities, amendments, etc.

1.3 **LETTER OF INTENT**

All interested offerors are requested to submit a non-binding **Letter of Intent** to respond to this RFP. While preferred, a Letter of Intent is not mandatory to submit a proposal.

The letter of intent must be received by the Department of Social Services via email no later than 05/17/2017 and must be addressed to Mark.Close@state.sd.us. Place the following, exactly as written, in the subject line of your email: **Letter of Intent for RFP #963**. Be sure to reference the RFP number in any attached letter or document.

1.4 **SCHEDULE OF ACTIVITIES (SUBJECT TO CHANGE)**

RFP Publication	<u>05/04/2017</u>
Letter of Intent to Respond Due	<u>05/17/2017</u>
Deadline for Submission of Written Inquiries	<u>05/17/2017</u>
Responses to Offeror Questions	<u>05/24/2017</u>
Proposal Submission	<u>06/14/2017 5:00 pm CDT</u>
Anticipated Award Decision/Contract Negotiation	<u>07/06/2017</u>

1.5 **SUBMITTING YOUR PROPOSAL**

All proposals must be completed and received in the Department of Social Services, Division of Medical Services by the date and time indicated in the Schedule of Activities.

Proposals received after the deadline will be late and ineligible for consideration.

An original, six (6) identical copies, and one (1) digital, Portable Document Format (PDF) copy loaded on a USB flashdrive of the proposal shall be submitted.

All proposals must be signed in ink by an officer of the responder legally authorized to bind the responder to the proposal, and sealed in the form intended by the respondent. Proposals that are not properly signed may be rejected. The sealed envelope must be marked with the appropriate RFP Number and Title. The words "Sealed Proposal Enclosed" must be prominently denoted on the outside of the shipping container. **Proposals must be addressed and labeled as follows:**

**Request For Proposal #963 Proposal Due 06/14/2017
South Dakota Department of Social Services
Attention: Mark Close
700 Governors Drive
Pierre SD 57501-2291**

No punctuation is used in the address. The above address as displayed should be the only information in the address field.

No proposal may be accepted from, or any contract or purchase order awarded to any person, firm or corporation that is in arrears upon any obligations to the State of South Dakota, or that otherwise may be deemed irresponsible or unreliable by the State of South Dakota.

1.6 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS

By signing and submitting this proposal, the offeror certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation, by any Federal department or agency, from transactions involving the use of Federal funds. Where the offeror is unable to certify to any of the statements in this certification, the bidder shall attach an explanation to their offer.

1.7 NON-DISCRIMINATION STATEMENT

The State of South Dakota requires that all contractors, offerors, and suppliers doing business with any State agency, department, or institution, provide a statement of non-discrimination. By signing and submitting their proposal, the offeror certifies they do not discriminate in their employment practices with regard to race, color, creed, religion, age, sex, ancestry, national origin or disability.

1.8 MODIFICATION OR WITHDRAWAL OF PROPOSALS

Proposals may be modified or withdrawn by the offeror prior to the established due date and time.

No oral, telephonic, telegraphic or facsimile responses or modifications to informal, formal bids, or Request for Proposals will be considered.

1.9 OFFEROR INQUIRIES

Offerors may email inquiries (separately from Letters of Intent emails) concerning this RFP to obtain clarification of requirements. No inquiries will be accepted after 05/17/2017. Email inquiries must be sent to mark.close@state.sd.us with the following wording, exactly as written, in the subject line: **RFP #963 Questions**.

The Department of Social Services (DSS) will respond to offerors inquiries by posting all offeror aggregated questions and Department responses on the DSS RFP website at <http://dss.sd.gov/keyresources/rfp.aspx> no later than 05/24/2017. For expediency, DSS may combine same or similar questions from multiple offerors. Offerors may not rely on any other statements, either of a written or oral nature, that alter any specification or other term or condition of this RFP. Offerors will be notified in the same manner as indicated above regarding any modifications to this RFP.

1.10 PROPRIETARY INFORMATION

The proposal of the successful offeror(s) becomes public information. Proprietary information can be protected under limited circumstances such as client lists and non-public financial statements. Pricing and service elements are not considered proprietary. An entire proposal may not be marked as proprietary. Offerors must clearly identify in the Executive Summary and mark in the body of the proposal any specific proprietary information they are requesting to be protected. The Executive Summary must contain specific justification explaining why the information is to be protected. Proposals may be reviewed and evaluated by any person at the discretion of the State. All materials submitted become the property of the State of South Dakota and may be returned only at the State's option.

1.11 LENGTH OF CONTRACT

The ontract start date will be mutually agreed upon by both parties with a proposed contract start date of June 1, 2017. The contract period will run through June 30, 2018 with the option to renew for three (3) additional years, in a one (1) year increment at the discretion of the State.

1.12 GOVERNING LAW

Venue for any and all legal action regarding or arising out of the transaction covered herein shall be solely in Hughes County, State of South Dakota. The laws of South Dakota shall govern this transaction.

1.13 DISCUSSIONS WITH OFFERORS (ORAL PRESENTATION/NEGOTIATIONS)

An oral presentation by an offeror to clarify a proposal may be required at the sole discretion of the State. However, the State may award a contract based on the initial proposals received without discussion with the offeror. If oral presentations are required, they will be scheduled after the submission of proposals. Oral presentations will be made at the offeror's expense.

This process is a Request for Proposal/Competitive Negotiation process. Each Proposal shall be evaluated, and each respondent shall be available for negotiation meetings at the State's request. The State reserves the right to negotiate on any and/or all components of every proposal submitted. From the time the proposals are submitted until the formal award of a contract, each proposal is considered a working document and as such, will be kept confidential. The negotiation discussions will also be held as confidential until such time as the award is completed.

2.0 STANDARD AGREEMENT TERMS AND CONDITIONS

Any contract or agreement resulting from this RFP will include, at minimum, the State's standard terms and conditions as seen in [Attachment B](#). As part of the negotiation process, the contract terms listed in [Attachment B](#) may be altered or deleted. The Offeror should indicate in their response any issues they have with any specific contract terms. If the Offeror does not indicate any contract term issues, then the State will assume the terms are acceptable.

3.0 SCOPE OF WORK

An efficient and robust Medicaid program is essential to the Department of Social Services' vision of strong families as being South Dakota's foundation and future. One of the key components to an effective Medicaid program is the distribution of the Electronic Health Record Incentive Payments to qualified providers.

The selected offeror must have the capacity, requisite experience, and expertise to provide an effective, efficient strategy for the South Dakota Department of Social Services (DSS) to meet the federal audit strategy requirements of the Medicaid Electronic Health Records Incentive Program.

- 3.1 The offeror may propose alternative tasks, broader tasks, or a different sequence of tasks (both within the auditing tasks and broader tasks outside of the auditing that are associated with South Dakota's administration of the EHR incentive program including completing updates of federal documents like the Implementation Advanced Planning Document (IAPD) and the State Medicaid Health Information Technology Plan (SMHP)) if they meet or exceed the essential responsibilities described in this RFP. However, DSS has an auditing strategy approved by CMS that must be followed. Proposed alternative tasks may need to be submitted for review and approval to CMS.
- 3.2 The offeror will conduct the activities and requirements listed in the approved audit strategy in [Attachment A](#) for post payment MU audits. The proposal must address how the offeror will conduct the audit tasks in order to implement the Scope of Work successfully including the following tasks:
 - 3.2.1 Initiate the audit
 - 3.2.2 Conduct the audit
 - 3.2.3 Report the audit results to DMS
 - 3.2.4 Document the audits

The offeror will identify any information or resources needed for the State in order to execute this Scope of Work

- 3.3 The offeror's response must include an executive summary, detailed narrative, project work plan, work flow diagram, description of the company, a list of references and contacts for other Medicaid Electronic Health Records auditing contracts, and a proposed detailed schedule and timeline for the execution of the project.
- 3.4 The offeror will be granted access to the SLR to review the attestation data. The offeror will be required to complete [Attachment C](#), the Business Associate Agreement, at the time of contract signing.

4.0 PROPOSAL REQUIREMENTS AND COMPANY QUALIFICATIONS

- 4.1 The offeror is cautioned that it is the offeror's sole responsibility to submit information related to the evaluation categories and that the State of South Dakota is under no obligation to solicit such information if it is not included with the proposal. The offeror's failure to submit such information may cause an adverse impact on the evaluation of the proposal.
- 4.2 **Offeror's Contacts:** Offerors and their agents (including subcontractors, employees, consultants, or anyone else acting on their behalf) must direct all of their questions or comments regarding the RFP, the evaluation, etc. to the point of contact of the buyer of record indicated on the first page of this RFP. Offerors and their agents may not contact any state employee other than the buyer of record regarding any of these matters during the solicitation and evaluation process. Inappropriate contacts are grounds for suspension and/or exclusion from specific procurements. Offerors and their agents who have questions regarding this matter should contact the buyer of record.

- 4.3 The offeror (**MUST** submit) a copy of their most recent independently audited financial statements.
- 4.4 Provide the following information related to at least three previous and current service/contracts performed by the offeror's organization which are similar to the requirements of this RFP. Provide this information for any service/contract that has been terminated, expired or not renewed in the past three years:
- a. Name, address and telephone number of client/contracting agency and a representative of that agency who may be contacted for verification of all information submitted;
 - b. Dates of the service/contract; and
 - c. A brief, written description of the specific prior services performed and requirements thereof.
- 4.5 The offeror must submit information that demonstrates their availability and familiarity with the locale in which the project (s) are to be implemented.
- 4.6 The offeror must detail examples that document their ability and proven history in handling special project constraints.
- 4.7 The offeror must describe their proposed project management techniques.
- 4.8 If an offeror's proposal is not accepted by the State, the proposal will not be reviewed/evaluated.

5.0 PROPOSAL RESPONSE FORMAT

- 5.1 An original and six (6) copies shall be submitted.
- 5.1.1 In addition, the offeror must submit one (1) copy of their entire proposal, including all attachments and cost proposal(s), in PDF digital format loaded on a USB flashdrive. Offerors may not send the electronically formatted copy of their proposal via email.
 - 5.1.2 The proposal should be page numbered and should have an index and/or a table of contents referencing the appropriate page number.
- 5.2 All proposals must be organized and tabbed with labels for the following headings:
- 5.2.1 **RFP Form.** The State's Request for Proposal form completed and signed.
 - 5.2.2 **Executive Summary.** The one or two page executive summary is to briefly describe the offeror's proposal. This summary should highlight the major features of the proposal. It must indicate any requirements that cannot be met by the offeror. The reader should be able to determine the essence of the proposal by reading the executive summary. Proprietary information requests should be identified in this section.
 - 5.2.3 **Detailed Response.** This section should constitute the major portion of the proposal and must contain at least the following information:
 - 5.2.3.1 A complete narrative of the offeror's assessment of the work to be performed, the offeror's ability and approach, and the resources necessary to fulfill the requirements. This should demonstrate the offeror's understanding of the desired overall performance expectations.
 - 5.2.3.2 A specific point-by-point response in the order listed, to each requirement in the RFP as detailed in Sections 3 and 4 and described further in the State's Audit Strategy ([Attachment A](#)). The response should identify each requirement being addressed as enumerated in the RFP.

5.2.3.3 A clear description of any options or alternatives proposed.

- 5.2.4 **Cost Proposal.** Cost will be evaluated independently from the technical proposal. Offerors may submit multiple cost proposals. All costs related to the provision of the required services must be included in each cost proposal offered.

See section 7.0 for more information related to the cost proposal.

6.0 PROPOSAL EVALUATION AND AWARD PROCESS

- 6.1 After determining that a proposal satisfies the mandatory requirements stated in the Request for Proposal, the evaluator(s) shall use subjective judgment in conducting a comparative assessment of the proposal by considering each of the following criteria listed in order of importance:
- 6.1.1 Specialized expertise, capabilities, and technical competence as demonstrated by the proposed approach and methodology to meet the project requirements;
 - 6.1.2 Resources available to perform the work, including any specialized services, within the specified time limits for the project;
 - 6.1.3 Record of past performance, including price and cost data from previous projects, quality of work, ability to meet schedules, cost control, and contract administration;
 - 6.1.4 Proposed project management techniques;
 - 6.1.5 Cost proposal.
 - 6.1.6 Availability to the project locale;
 - 6.1.7 Familiarity with the project locale; and
 - 6.1.8 Ability and proven history in handling special project constraints.
- 6.2 Experience and reliability of the offeror's organization are considered subjectively in the evaluation process. Therefore, the offeror is advised to submit any information which documents successful and reliable experience in past performances, especially those performances related to the requirements of this RFP.
- 6.3 The qualifications of the personnel proposed by the offeror to perform the requirements of this RFP, whether from the offeror's organization or from a proposed subcontractor, will be subjectively evaluated. Therefore, the offeror should submit detailed information related to the experience and qualifications, including education and training, of proposed personnel.
- 6.4 The State reserves the right to reject any or all proposals, waive technicalities, and make award(s) as deemed to be in the best interest of the State of South Dakota.
- 6.5 **Award:** The requesting agency and the highest ranked offeror shall mutually discuss and refine the scope of services for the project and shall negotiate terms, including compensation and performance schedule.
- 6.5.1 If the agency and the highest ranked offeror are unable for any reason to negotiate a contract at a compensation level that is reasonable and fair to the agency, the agency shall, either orally or in writing, terminate negotiations with the contractor. The agency may then negotiate with the next highest ranked contractor.

- 6.5.2 The negotiation process may continue through successive offerors, according to agency ranking, until an agreement is reached or the agency terminates the contracting process.

7.0 **COST PROPOSAL**

South Dakota has made incentive payments for Adopt, Implement, Upgrade (AIU) to 391 eligible providers as of February 1, 2017. Approximately 20 MU Audits are conducted a year. Program year 2016 is the last year a provider can join the Medicaid Electronic Health Records Program as a new provider with the program anticipated to end in 2021. As time goes by less providers will be attesting as they have reached their maximum allowable payments. The offeror's proposal must include costs per eligible professional ;MU audit and costs per eligible professional MU. The MU audit should include all costs but not limited to: required staff, travel, materials, and incidentals, among others. The offeror should also include the costs for other suggested tasks or services. Use [Attachment D](#) when submitting the cost proposal.

Attachment A



Strong Families – South Dakota's Foundation and Our Future
South Dakota Department of Social Services

Division of Medical Services

Audit Strategy

EHR Incentive Payment Program

Version 1.3
June 23, 2015

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THE AUDIT STRATEGY

The audit plan describes the strategy to ensure accurate payments, the process for combating fraud and abuse by verifying criteria related to the EHR Incentive Payment Program, as well as a description of the process and methodology to address Federal laws and regulations designed to prevent fraud, waste, and abuse.

1. Overview

South Dakota (SD) is leveraging the existing audit strategies in place for fraud and abuse detection and also to ensure accurate payments for the electronic health records (EHR) Incentive Payment Program. Suspected fraud or abuse involving EHR incentive payments can be reported through existing means such as the Surveillance and Utilization Review Subsystem (SURS) and Medicaid Fraud Control Unit's (MFCU) fraud hotline and fraud email account.

To prevent improper payments, fraud, waste and abuse, the EHR Incentive Payment Program works with the SURS unit or Department of Social Services (DSS) Provider Reimbursements and Audits staff, dependent on staff availability.

The SURS unit within Division of Medical Services (DMS) has a Payment Control Officer and four investigators. The SURS unit is tasked with safeguarding against unnecessary or inappropriate use of DMS services or excess payments; assesses the quality of those services; and conducts post-payment reviews to monitor the use of health services.

DMS Provider Reimbursement conducts post-payment audits for those providers attesting to Adopt, Implement, or Upgrade (AIU). DSS Provider Reimbursement and Audits has 4 internal auditors. The responsibilities of Provider Reimbursements and Audits are to establish reimbursement methodology and reimbursement rates. They also provide other auditing services for programs within the Department of Social Services for the verification of the provider's program costs and for compliance to the established reimbursement requirements of the applicable program.

DMS has contracted with XXXXX to conduct Stage 1 and Stage 2 Meaningful Use (MU) audits on Medicaid Eligible Providers (EPs).

DMS designates CMS and its contractors to perform audits on Medicare and dually-eligible Eligible Hospitals (EH). DMS agrees to the following:

- (1) Designate CMS to conduct all audits and appeals of EHs meaningful use attestation**
- (2) Be bound by the audit and appeal findings**
- (3) Perform any necessary recoupments arising from the audits**
- (4) Be liable for any Federal Financial Participation (FFP) granted to the state to pay EHs that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users.**

Any adverse CMS audits would be subject to the CMS administrative appeals process and not the state appeals process.

We acknowledge that DMS will remain responsible for auditing all other aspects of eligibility for EHs for incentive payments, including, but not limited to (1) adopt, implement or upgrade (AIU); (2) patient volume; (3) average stay length; and (4) calculation of the payment amounts.

2. Guiding Principles

The Division of Medical Services (DMS) audit strategy will be based on the following general guiding principles:

- Any eligible professional or eligible hospital attesting through the SD Medicaid EHR Incentive Payment Program will undergo pre-payment verification and may be subject to a post-payment audit.
- The audit strategy will be flexible to accommodate AIU, and MU stages 1, 2, and 3.
- DMS will apply several methods to reduce provider burden while maintaining integrity of the oversight process. Through the statewide HITECH multi-collaborative, DMS expects to have a broader reach to providers. DMS has collaborated with the Regional Extension Center (REC), HealthPOINT, to communicate and share accurate information regarding the EHR Incentive Payment Program with providers. In addition, DMS sends a clear and consistent message to providers through its communication strategy and the resources for providers to use in the program. DMS communication with providers has improved their understanding of the program, which in turn has resulted in a decrease of abuse and non-compliance. DMS will also use claims data, immunization registry and electronic lab reporting, the SD Health Link/planned Health Information Exchange (HIE), and external data sources for verification reducing provider burden.

3. Methodology

DMS utilizes existing oversight activities and integrate processes related to the incentive program into audits and reviews already in place. The DMS EHR Incentive Payment Program's audit strategy is composed of two main components:

1. DMS avoids making improper payments by ensuring that all payments are made according to EHR incentive funding requirements to Eligible Professionals (EPs) and Eligible Hospitals (EHs) through a combination of monitoring and validation prior to payment. This includes SD Medicaid EHR incentive attestation portal system edits and manual review of red flags/high risk elements.
2. DMS ensures proper payments through selective and targeted audits after payments are disbursed. The post payment audits will consist of primary and secondary data source validation and of targeted and random sampling of EH and EP paid providers.

DMS relies heavily on pre-payment verifications to ensure proper payment. EHR incentive program staff performs pre-payment verifications. The audit pool for post-payment audits will be composed of flagged providers during pre-payment checks and areas where system edits lack. Risk based elements will be identified to assess which eligibility, AIU, and MU measures are likely to be subject to incorrect information. At a minimum, DMS will conduct audits on at least 10% of all providers receiving incentive payments. Then a three-tiered approach will be used for post-payment audit to validate submitted attestations. The three-tiered approach will be composed of primary, secondary, and alternate data analysis.

3.1 Three-Tiered Approach

3.1.1 Tier 1: Primary Data Validation

DMS will leverage existing resources currently available including data in the MMIS, provider enrollment subsystem, extracted claims data, and hospital cost report data for disproportionate share hospital (DSH) reports for primary data validation. .

South Dakota does not have an All Payer's Claims Database (APCD) at this time to verify non-Medicaid claims.

Inter-criteria comparison will be used to examine inconsistency in attestation responses as several MU measures use the same denominators. Also, consistency in the reported patient encounters, EHR certification numbers, documentation and other requirements among EPs using group patient volume will be reviewed.

3.1.2 Tier 2: Secondary Data Validation

Review of provider submitted documentations such as practice management system reports, billing reports, financial and accounting data, NLR level data (Research & Support User Interface and Microstrategy Business Intelligence reports data) and additional auditable data will be performed. Medicare and Medicaid cost reports, Department of Health (DOH) Electronic Lab Reporting (ELR) and immunization registry (IR) will be consulted.

3.1.3 Tier 3: Alternate Selection Approach

The alternate method targets providers that were not flagged during tier 1 and tier 2 validations. Targeted audits made on a selective basis as well as post-payment review of the random audits will be completed. Criteria for targeted audits include:

- Providers with largest hospital incentive payments (AIU only or Medicaid eligibility)
- A provider that has reported invalid information or submitting insufficient credible information to support attestation. For example, this includes not submitting/uploading appropriate AIU/MU documentation
- A provider that has become subject of unrelated program integrity review
- A provider that selects to inactivate their status as Medicaid provider or is terminated from the Medicaid program
- Or by a referral
- An EP practices predominantly in an FQHC or RHC and claims needy individual patient volume and the needy individual data is required to achieve the 30% patient volume threshold.
- An EP working at multiple FQHC/RHC locations must meet the 50% of total encounters over a period of 6 months in the most recent calendar year. DMS will work with HealthPOINT and/or the provider to verify multiple payers' data. This is considered a low risk element and more likely to be audited only if other concerns were raised during post payment.
- EPs in large practice groups of 15 or more providers with 100% of the EPs attesting for EHR incentive payments

4. Pre-Payment Verification Methods, Audit Elements and Sources

The DMS staff of the EHR Incentive Payment Program will be responsible for pre-payment audits. DMS will use primary and secondary data sources for audit. As part of the attestation process, providers indicate whether they are working with an REC, such as HealthPOINT. If the provider is

using the services of HealthPOINT, DMS will coordinate with HealthPOINT to validate whether the provider is using a certified EHR, or whether the provider has achieved MU. DMS will work with providers and HealthPOINT to assist EPs and EHs to meet the requirements of AIU/MU prior to applying for incentive payment.

DMS will verify attestation information submitted by providers and will perform high level checks; some manual verification will be used. While currently, there is a single DMS staff person conducting the pre-verification eligibility for incentive payments; a report is generated from the MMIS for final approval of the incentive payment disbursement. Below is a detailed narrative on selected audit elements.

4.1 Eligibility

4.1.1 Enrollment

The provider must be enrolled with Medicaid in DMS. This will be verified through a system check in MMIS/SD MEDX. Verification will be made through the National Level Repository (NLR) and MMIS including provider name, NPI, business address, phone, the tax identification number (TIN) to which provider would like payments made, CMS Certification Number (CCN), the state from which providers are applying to receive incentive payments, and group affiliations. DMS maintains a list of hospitals and CCNs. If a provider is not an actively enrolled provider, the system edits in MMIS are in place to prevent non-enrolled providers from payment. This is a low risk element.

4.1.2 Licensed, Non-sanctioned/Excluded

The provider must not be sanctioned and is properly licensed. There are existing auditing strategies in place to ensure that providers are enrolling and actively participating in the DMS program, billing and receiving payment in MMIS/SD MEDX system, and are licensed and not sanctioned. An active provider is one who is active in the Medicaid Management Information System (MMIS) and approved to bill for services. Active Medicaid providers are providers who are not currently under sanctions and are duly licensed within the state. DMS provider enrollment process encompasses these checks prior to enrollment. During the pre-payment audit, the provider enrollment checks will be repeated including checks in MMIS, provider enrollment files, Office of the Inspector General Exclusion list/List of Excluded Individuals/Entities, program integrity files, and state licensing boards. An exception for licensure is for Indian Health Services (IHS) providers as they are not required to be licensed in the State in which they practice for IHS. IHS providers are exempt from having to hold a SD License pursuant to South Dakota Codified Law (SDCL 36-2-8.). DMS may consider the use of IHS practice management, meaningful use and other systems for verification of requirements for IHS providers. This is a low risk element.

4.1.3 Non-hospital based

DMS will verify whether or not an individual EP is hospital based by analyzing an EPs Medicaid claims data sources from the preceding calendar year. If the EP is hospital based, then the EP would provide 90% or more of their services in an inpatient or emergency room setting (Place of Service codes of 21 and 23). This verification is performed by a manual query of the claims database per EP except when the provider is practicing predominantly in an FQHC/RHC setting. This is a low risk element.

4.1.4 Physician Assistant (PA)-led FQHC/RHC

1. The PA is the primary provider in the FQHC or RHC
2. The PA is a clinical or medical director at a FQHC/RHC clinical site of practice
3. The PA is an owner of an RHC

If an FQHC or RHC has multiple sites and one of them is led by a PA, then PAs in all sites are eligible for the program.

Prepayment verification of “primary provider” verification will take into account when compared to other providers in the clinic, the PA:

1. Is assigned the most patients in the clinic
2. Has the most patient encounters
3. Has the most practice hours
4. Has more Full time PAs than more full time physicians
5. Is a single provider

The clinical or medical director at a FQHC/RHC clinical site of practice and ownership or RHC roles for PAs can be validated with documentation including public documents and internal data provided on the Provider Enrollment subsystem. If needed, DMS will be requesting dated documentation from FQHCs and RHCs from which one or more PAs apply, including position descriptions, emails, meeting minutes and other organizational documents that yield conclusive indications of clinical leadership. RHC ownership documentation, the physician or PA collaborative agreement, review of the clinic practice management system for patient loads or clinic organizational documents supporting clinical director role, and Uniform Data Systems (UDS) reports may be requested if PA led criteria is unclear. DMS maintains a pre-determined list of FQHC/RHC clinics. Furthermore, FQHC/RHCs work closely with HealthPOINT to attest for incentives. This is considered as a low risk element due to a low number of PA led FQHCs/RHCs.

4.1.5 Participate in Medicare and Medicaid

If an EH participates in both Medicaid and Medicare, then audit checks at the CMS Registration and Attestation System National Level Repository (NLR) level will be adopted except for verification of the eligibility, the 10% minimum Medicaid patient volume, and other state level requirement checks done by DMS. If the provider is an EP, they were able switch programs once before 2014; an option that is no longer available. EHs deemed a meaningful user under the Medicare EHR Incentive Payment Program will be a meaningful user under the DMS program if other eligibility requirements are met. NLR level reports will be used to verify participation information for providers including if an EP switched between Medicare and Medicaid programs more than once.

4.1.6 Certified Electronic Health Record Technology

DMS utilizes the Medicaid HITECH TA site CMS Certification ID Look-up facility to manually verify the attested CMS Certification ID is for certified EHR technology. Further, we obtain the Product Name from the Look-up to access CHPL to verify the CEHRT Edition.

4.1.7 Patient Volume Calculation Method

DMS will continue to closely work with providers to ensure accurate numerators, denominators, and calculations demonstrate patient volume that is as flexible and as

inclusive as possible while balancing the administrative burden. The attestation portal captures the EP patient encounter's information (including those practicing in an FQHC/RHC) and calculates the minimum 90-day patient volume of 30% and pediatrician's demonstration of 20% patient volume in a calendar year. Upon capturing the relevant information from EHs, the attestation portal calculates the Medicaid patient volume to determine the minimum 10% Medicaid patient volume except for Children's Hospital.

- When the provider enters the start date for demonstrating patient volume, the incentive attestation portal calculates the end date of the 90-day period.
- The provider is prompted to enter patient volume in any continuous and representative 90-day period the previous year. DMS has system edits in place for patient volume reported in previous year based on program participation year. Initially, a manual check was performed to ensure that patient volume was reported in the previous year.
- For eligible professionals, if the provider is attesting as a group, then the group Medicaid patient encounters is checked for reasonableness through queries on the claims database. Staff verifies that EPs within their group practice report encounters that are consistent. Also staff will look for any indications if an EP that belongs to a group attested individually. Staff will outreach to maximize EP participation since this will affect other EPs attestations in the same group.
- Calculations of patient volumes also are automated in the portal. When the provider enters the numerator and denominator, the portal calculates the patient volume percentage to determine eligibility. Providers not meeting the minimum patient volume thresholds would not be able to submit attestation. The EHR incentive program staff uses claims database to validate the Medicaid encounter (numerator). If there is a significant difference with the submitted numerator and claims validation (>15% difference), the eligible professionals and hospitals will be requested to submit auditable documentation. This will be a high risk element.
- Children's Health Insurance Program – As it is difficult for EPs to determine which patients are Medicaid vs CHIP, South Dakota applied a CHIP factor to a provider's attested volume. The CHIP factor is developed on a per county basis and revised annually. The appropriate county fact or is applied to the EPs Medicaid patient volume (numerator) in the pre-payment review of the submitted patient volumes. This factor was applied for program years 2011 and 2012 only

Numerator and denominator calculations can be further verified if the providers already have existing EHRs with a review of EHRs or practice management information. Otherwise, DMS will work with the provider to determine acceptable proof. These may include copies of schedules, claims to different payers, billing records and other auditable proofs. For individuals with needy patient volume calculations, DMS will depend on the records of the FQHCs, RHCs and copies of billing records. Other documentation may be required. DMS will work with these facilities individually to ensure that all patients on Medicaid, CHIP or adjusted fees according to income are counted in the numerator. As FQHCs/RHCs submit Medicaid/CHIP claims, encounter data, and clinic data to Health Resources & Services Administration (HRSA,) DMS may also verify individuals with needy volume through claims by source of payment submitted to HRSA.

Verification of Indian Health Services (IHS) provider is similar to the verification process used with FQHC and RHCs. The Tribal clinic is verified; if the attesting provider is a PA the “so led” requirements is verified; and the practice predominantly and verification of “needy encounters” is done the same as FQHC/RHC. Also, IHS providers are exempt from the “non-hospital based” requirement.

The DMS pre-payment review has been updated to include the 2013 changes specified in the 2012 Stage 2 regulations as well as the options offered by the 2014 Flexibility Rule.

DMS collaborates with other state Medicaid agencies to verify out of state Medicaid encounters if a provider included encounters from Border States to meet the minimum patient volume threshold.

4.1.8 2014 CEHRT Flexibility Rule

DMS implemented the changes for the 2014 Flexibility Rule at the end of 2014. The changes included allowing a provider to indicate they were attesting via the Flexibility rule, which in turn presented the options offered. After the provider indicated which program year/Stage they were attesting to, the system presented the appropriate screen. DMS requests the appropriate documentation (vendor letter) during the pre-payment verification process

4.1.9 Average Length of Stay (LOS)

To verify that Acute Care hospitals meet the average LOS requirement of 25 days or fewer in the fiscal year prior to the payment year, Medicaid/Medicare cost reports, MMIS claims data, utilization and hospital records will be consulted. Providers may be required to submit auditable data source such as financial reports, accounting records and cost reports if necessary. Based on the provider self-attestation, the portal calculates Average LOS and system edits are in place. This is a low risk element.

Eligibility Prepayment Verification		
Risk Category	Electronic/Manual Sources	Risk Level
Provider must be of an eligible type (EP/EH type)	Automated checks in portal; MMIS, provider files	Low
Provider must be enrolled in DMS	MMIS, SD MEDX, provider enrollment files	Low
Provider must not be sanctioned and is properly licensed/not excluded	MMIS, provider enrollment files, Office of the Inspector General exclusion list/List of Excluded Individuals/Entities, program integrity files, state licensing/accreditation boards, associations, NLR Research and Support User Interface (R&S UI)	Low
Provider must not be hospital based unless practicing in FQHC/RHC	MMIS claims data	Low
For individuals with needy patient volume, EP practices in FQHC/RHC	MMIS claims data show Medicaid and CHIP, provider enrollment records, practice management system records, and other auditable resources	High
PA's at FQHC/RHCs that are “so led” by PA	RHC ownership documentation in SD MEDX, the physician or PA collaborative agreement, review of the	Low

	clinic practice management system for patient loads or clinic organizational documents supporting clinical director role	
Eligible professional participates in both Medicaid and Medicare	NLR R&S UI and micro-strategy reports	Low
Patient volume is reported in the previous year	Manual check based on attestation detail, program year, payment year, and date of attestation	Medium
Patient volume is reported for 90 continuous days	Automated 90-day calculation in portal	Low
Patient Volume calculation: 30% for EPs using Medicaid volume and individuals with needs; 20% for pediatricians; 10% for Acute Care and Critical Access Hospitals	MMIS Medicaid/CHIP claims data, HealthPOINT, auditable payer data, practice management reports, HRSA reports and Medicaid encounters. All payer data may be requested/required to check denominator	High
Average Length of Stay (LOS) 25 days or fewer for Acute Care hospitals	Cost reports, financial/accounting statements, and MMIS data	Low
No EP or EH begins receiving payments after 2016 and payments end by 2021	Automated participation years check in portal, MMIS, NLR R&S UI, and micro-strategy reports	Low

4.2 Meaningful Use

As DMS began accepting Stage 1 MU attestations from providers in the fall of 2012 and Stage 2 MU from providers in 2014 (program year 2014), a review of meaningful use attestations will be performed after issuing a meaningful use incentive payment. Any EH deemed a meaningful user under the Medicare EHR Incentive Program will be a meaningful user under the DMS Medicaid EHR incentive program if other eligibility requirements are met. Prior to issuing payment, staff will perform Medicaid eligibility requirement reviews based on information provided in the attestation portal. Audit of dual Medicare and Medicaid EHs for meaningful use measures will be done by CMS. DMS plans to audit all Medicaid requirements of EHs except for meaningful use measures. DMS will work with HealthPOINT, DOH and providers to verify the reported Core, Menu and Clinical Quality Measures (CQMs).

Numerous system edit checks are built into the SD Medicaid EHR Incentive Payment portal for meaningful use. Calculation of thresholds for meeting core and menu measures is automated in the attestation portal. Providers must attest to and be able to demonstrate core, selected menu, and clinical quality measures and provide verifiable documentation. Juxtaposing numerator /denominator and yes/no measures including in the portal prompts the provider to include explanations for certain measures to aid with audit. The attestation portal enables the provider to enter explanations for exclusions, detail e-Prescription (eRx) service and pharmacy, name CDS rule, specify with whom a test for clinical information exchange was done, and name a condition for patient list. These are used to mainly support post-payment audit but may also be used during pre-payment.

The attestation portal allows the uploading of supporting documentation and explanations. Providers who have not submitted supporting documentation such as CQM measures from direct output of EHRs may have an elevated risk level for audit. Validation of CQMs completeness is automated in the portal. Once providers begin submitting meaningful use core, menu and clinical quality measures, DMS staff will conduct the following high-level checks:

- Confirm that clinical quality measures have been submitted to DMS. Validation of CQMs completeness is automated in the portal. For 2012 and beyond, completeness of CQMs will be checked according to the requirements of the submitted program year.
- Validation of Yes/No and Numerator/Denominator calculations for meeting thresholds is automated in the attestation portal.
- A review of the aggregate or statistical reports generated by the EHR confirming the measures of meaningful use (core and selected menu measures) of those indicated via attestation will be matched. Practice management documents may be consulted. If a standard report is not available, staff will work with the provider to determine an acceptable process for verification if requested. This will be data mainly reviewed during post-payment audit
- Review documentation confirming the exchange or testing of electronic health records. Once operational, the HIE will be a source of verification.
- If a provider is working with HealthPOINT, DMS will collaborate with HealthPOINT to explore meaningful use data sources.

Meaningful Use Pre-payment Verification		
Risk Category	Low risk	Risk Level
MU EHR reporting period, 90 days in first year, 1 year in subsequent years, if applicable	Automated calculation of 90 days and 1 year, if applicable,	Low
Year of participation	Automated in portal, manual check with NLR R&S UI, Microstrategy and BI reports	Low
50% of all encounters take place in locations with certified EHR	Manual review of MMIS, provider documentation, attestation portal, and CHPL	Medium
MU Numerator/Denominator calculations	Automated in portal and validated for meeting thresholds	Low
MU Yes/No	Automated check for completeness	Low
MU exclusions- provider enters reason for exclusion on attestation portal	Manual reasonableness check per uploaded evidence or explanations	Medium
MU core requirements are attested and accurate-reasonableness check for measures with similar denominators	Manual check for measures with similar denominators, reasonableness of exclusions explanations or documentation upload, and public health measure verification, EHR reports, HIE, and HealthPOINT data	See section below
MU menu requirements are attested and accurate/reasonableness check for measures with similar denominators	Manual check for measures with similar denominators, reasonableness of exclusions explanations or documentation upload, and public health measure verification/DOH, HIE/HealthPOINT, EHR and practice management data	See section below
Clinical Quality Measures are attested, complete, and verifiable	Automated check for completeness in the attestation portal, HIE/HealthPOINT, EHR and practice management data	Low risk
Flexibility Rule attestation – 2014 program year only	The EP submits sufficient evidence demonstrating their 2014 attestation was caused by their CEHRT vendor delay in implementation the 2014 Edition CEHRT	Medium

4.2.1 Public health measures

Public health data submission validation: Public health exchange will be a source for verification of data submissions to immunization registry and/or public health electronic lab reporting

(ELR). Menu measures related to public health reporting will be checked with the SD public health exchange (both the Immunization Registry and Electronic Lab Reporting) that it has been implemented. Syndromic surveillance sources from DOH have been developed and are currently in the pilot stage. DMS collaborates with DOH and has access to a database with a list of providers that have met the public health measures for meaningful use. This enables DMS to verify attestations if providers have met at least one or more of the public health measures.

Public Health Pre-Payment Measures verification	
Risk Category	Electronic/Manual Sources
EP Public Health Measures	
Stage 1 Menu 9; Stage 2 Core 16: Capability to submit electronic data to immunization registries	Manual; HIE/DOH Immunization registry
Stage 1 Menu 10; Stage 2 Menu 1: Capability to submit electronic syndromic surveillance data to public health agencies	Manual; HIE/ DOH Syndromic surveillance data
EH Public Health Measures	
Menu 8: Immunization registries data submission	Manual; HIE/DOH Immunization registry data
Menu 9: Reportable lab results to public health agencies	Manual; HIE/DOH hub ELR data
Menu 10: Syndromic surveillance data submission	Manual; HIE/DOH hub/Syndromic surveillance data

4.2.2 Measures with similar denominators

Validation that denominator values are the same for measures requiring “all Emergency Department (ED) visits method” or “observation services method” have the same numbers in the denominator. Stage 1 EP Measures with same denominators: measures requiring “unique patient count” during the reporting period should have the same numbers in the denominator.

- Core 3: Maintain Problem List - medium
- Core 5: Maintain active medication list - high
- Core 6: Maintain active medication allergy list - high
- Core 7: Record demographics - high
- Menu 5: Patient electronic access - medium
- Menu 6: Patient-specific education sources- medium

Stage 2 EP Measures with same denominators: measures requiring “unique patient count” during the reporting period should have the same numbers in the denominator.

- Core 3: Record Demographics - low
- Core 4: Record Vital Signs - low
- Core 7: Patient electronic access - medium
- Core 17: Use Secure Messaging - high
- Menu 4: Family Health History - low

As DMS has designated CMS to review EH MU measures, the following are only for high level review of an attestation. Final determination of MU eligibility will be by CMS, and DMS will wait for the CMS MU eligibility determination prior to approving a EH for payment.

Stage 1 EH Measures with same denominators: measures requiring “observation services method” or “all ED visits method” should have the same numbers in the denominator.

- Core 3: Maintain problem list - medium
- Core 4: Maintain active medication list - high

- Core 5: Maintain active medication allergy list - high
- Core 6: Record demographics - high
- Menu 5: Patient-specific education sources- medium

Stage 2 EH Measures with same denominators: measures requiring “observation services method” or “all ED visits method” should have the same numbers in the denominator.

- Core 2: Record demographics - low
- Core 3: Record Vital Signs - low
- Core 10: Patient-specific education sources- medium
- Menu 2: Electronic Notes - medium
- Menu 4: Family Health History - low

4.2.3 Measures with exclusions

Review of reasonableness for exclusions is based on specialty type, explanations provided in the attestation portal and any uploaded documentation if exclusions are claimed. Lack of submission of documentation may raise the level of risk profile for audit. DMS will explore secondary data sources, benchmarking and other approaches to validate exclusions post-payment.

Stage 1 EP exclusions:

- Core 1: Writes fewer than 100 prescriptions during the EHR reporting period of CPOE for medication orders
- Core 4: Writes fewer than 100 prescriptions during the EHR reporting period to report eRx rate
- Menu 1: Writes fewer than 100 prescriptions during the EHR reporting period to implement drug formulary checks
- Core 8: Sees no patients ≥ 2 years old or sees measure as having no relevance to practice to record vital signs
- Core 13: No office visits to provide clinical summaries for patients for each office visit
- Menu 4: No patients ≤ 5 year old or ≥ 65 year old for Patient Reminders
- Menu 2: Orders no lab tests to incorporate clinical lab test results into EHR as structured data
- Menu 5: Neither orders nor creates information to provide patients with timely electronic access to their health information
- Menu 7: Not a recipient of transitions of care to receive medication reconciliation
- Menu 8: Neither transfers a patient nor refers a patient to another provider for Send Transition of Care Summary
- Menu 10: Does not collect any reportable syndromic information to demonstrate capability to submit electronic syndromic surveillance data to public health agencies
- Core 9: No patients to Record smoking status for patients ≥ 13 year old
- Core 12: No patient information requests for Electronic copy of health information

Stage 2 EP exclusions:

- Core 1: Writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting period
- Core 2 Writes fewer than 100 prescriptions during the EHR reporting period or does not have a pharmacy accepting electronic prescriptions within 10 miles of their practice location

- Core 4: Sees no patients ≥ 3 years old or sees measure as having no relevance to practice to record vital signs
- Core 5: Sees no patients ≥ 13 years old during the EHR reporting period
- Core 6: (Measure 2) Writes fewer than 100 medication orders during the EHR reporting period
- Core 7: Neither orders or creates any of the patient information, or conducts 50% or more of their encounters in a county that does not have 50% or more of housing units with 3Mbps broadband availability
- Core 8: No office visits during the EHR reporting period
- Core 10: No applicable lab tests ordered during the EHR reporting period
- Core 12: No office visits in the 24 months prior to the EHR reporting period
- Core 13: No office visits during the EHR reporting period
- Core 14: Not on the receiving end of a transition of care during the EHR reporting period
- Core 15: Transfers patients for a transition of care less than 100 times during the EHR reporting period
- Core 16: does not administer immunizations; or operates in a jurisdiction without an immunization registry capable of accepting data or cannot accept the data timely during the EHR reporting period
- Core 17: No office visits, or conducts 50% or more of their encounters in a county that does not have 50% or more of housing units with 3Mbps broadband availability
- Menu 1: does not collect syndromic data; or operates in a jurisdiction without an syndromic surveillance registry capable of accepting data or cannot accept the data timely during the EHR reporting period
- Menu 3: Orders less than 100 imaging tests during the EHR reporting period or has no access to electronic imaging results at the start of the EHR reporting period
- Menu 4: No office visits during the EHR reporting period
- Menu 5: does not diagnose or treat a disease associated by a specialized registry; or operates in a jurisdiction without a specialized registry capable of accepting data or cannot accept the data timely during the EHR reporting period
- Menu 6: does not diagnose or treat cancer; or operates in a jurisdiction without a cancer registry capable of accepting data or cannot accept the data timely during the EHR reporting period

Program staff will outreach providers/designated contacts if exceptions exist to the initial pre-payment checks. Upon review of the pre-payment checks, program staff will document status on the pre-payment checklist.

4.2.4MU primary risk level

Post-payment audit of Meaningful Use Core and Menu measures will primarily target measures with high control risk where verification data is available.

As DMS has designated CMS to conduct EH post-payment MU audits, only EPs, which will be audited by DMS, are presented.

Stage 1 EP:

Core 2 Drug Interaction Checks

Core 10 Clinical Quality Measures (discontinued as a MU measure starting in 2013)

Core 11 Clinical Decision Support

Core 14 Electronic Exchange of Clinical Information (discontinued as a MU measure starting in 2013)

Core15 Protect Electronic Health Information

Menu 01 Drug Formulary Checks

Menu 3 Patient Lists

Stage 2 EP:

Core 1: CPOE for Medication, Laboratory, and Radiology Orders

Core 6: Clinical Decision Support

Core 9: Protect Electronic Health Information

Core15: Summary of Care

Menu 1: Syndromic Surveillance Data Submission

Menu 3: Imaging Results

4.3 EP/EH Retention of documentation

During attestation, EPs and EHs attest to the accuracy of the information submitted and include an agreement on the portal to retain records for a minimum of six years prior to submitting their attestation. For subsequent years, providers will be required to retain documentation for a minimum of six years from the date of an approved application that resulted in a SD Medicaid EHR incentive payment. Failure of providers to retain documentation for a minimum of six years will result in a review by DMS and may result in adverse action against the EP or EH, such as recoupment of incentive payment and other actions.

4.4 Payment Calculations

Payment amount validations are automated for EPs based on year of participation, type of professional, and number of payments. Payment amounts will be checked that EPs meeting 30% patient volume are for \$21,250 in the first year and at \$8,500 subsequent participation years. Attestation portal rules automatically apply the lower payment amount for Pediatricians meeting at least 20%-29% patient volume at \$14,167 the first year and \$5,667 subsequent years of participation.

Hospital cost reports and disproportionate share (DSH) surveys, audited financial reports and accounting records will be reviewed for accurate calculation of payment. The portal provides EHs correct lines to include from Medicare cost report worksheets. EHR incentive staff maintains estimated incentive projections and compare and work closely with EHs attestations to ensure accurate calculation of EH incentives. Hospitals with non-continuous cost reporting period will be monitored. The following should be satisfied for accurate payment calculation:

- Accurate lines from cost reports are used to calculate total discharges, Medicaid and hospital days, total hospital charges and charity care charges
- Dually-eligible hospitals are not including Medicare Part A or Part C acute inpatient days where Medicare was the primary payer
- Charity care charges or other uncompensated care charges are reported accurately
- Exclusion of nursery, observation, rehab and psych days (inclusion of acute inpatient days)

DMS will apply the most accurate information available at time of incentive calculation. DMS accepts up to a 5% variance in calculation of incentive payments for EHs. However, if variation is due to inaccurate data reported such as incorrect years or inclusion of non-acute inpatient bed days, then data would need to be reconciled to reflect correct payment calculation.

Payment Pre-payment Verification		
Risk Category	Electronic/Manual Sources	Risk Level
Payments for a maximum of six years for EP and maximum of three years for EH	Automated portal and MMIS Micro-strategy report	Low
No duplicate payments	NLR Micro-strategy reports, R&S UI, and automated in portal/MMIS	Low
Provider reassigning payment	NPI/TIN match in MMIS, both manual and automated	Low
Accurate calculation of EP payments	Automated in portal	Low
Accurate calculation of EH payments as submitted by the provider	Automated in portal, cost reports/auditable data	
Accurate lines and correct years from cost reports are used to calculate total discharges, Medicaid and hospital days, total hospital charges and charity care charges	Automated cost report lines displayed to provider on attestation portal, manual check of Medicare and Medicaid cost report, DSH, financial and accounting reports	Medium

Payment Pre-payment Verification		
Risk Category	Electronic/Manual Sources	Risk Level
Dually-eligible hospitals are not including Medicare Part A or Part C acute inpatient days where Medicare was the primary payer	MMIS claims data, and cost reports	Medium
Charity care charges or other uncompensated care charges are reported accurately	DSH and audited financial reports	Medium
Exclusion of nursery, observation, rehab and psych days (inclusion of acute inpatient days)	Manual check of cost report, MMIS	Low

5. Payment

In order to avoid improper or duplicate payments, the EHR Incentive Payment Program staff will check the National Level Repository, Microstrategy reports and Research and Support User Interface prior to authorizing payments and update the NLR with payments made. To avoid any underpayments or overpayments, incentive payments will be reviewed by both program managers and finance staff. Upon successful duplicate payment check, payment files are generated. Incentive payments to EPs and EHs will be disbursed through MMIS. This will guarantee validity on provider TINs, and edits and fund codes have been applied in order to separately track EHR incentive payments. Incentive payments are reported and monitored through the CMS-64 financial report. The number of payments, year of payment, payment amount, and payment dates are automated and tracked in attestation portal and MMIS per provider.

6. Post-payment Audits

Audits may be either desk reviews or field audits. A combination of primary, secondary, and risk assessment approach described in Section 6.3 will be used to validate flagged providers for post-payment audit. All audits will initially be conducted as desk audits;

6.1 AIU Audits

The South Dakota SURS or Provider Reimbursements and Audits will perform audits of AIU post-payments for further in-depth review of first year payments. Risk assessment of AIU attestations are done as part of the pre-verification process as well as after EPs and EHs receive payment. The risk assessment results in classification of AIU attestation into High, Medium, and Low risk categories. The risk assessment is inclusive of every EP and EH so that every provider has a chance of being picked for review. The number of AIU audits performed is based upon risk categories; all providers in the “high” risk category are audited; and 10% of the providers in the “Medium” risk category and 10% of the providers in the “Low” category are chosen for audits. The AIU audit is conducted using the data in the attestation portal and documents received from EP or EH for AIU payments. If more information is required to complete the desk audit, the appropriate audit staff will outreach the contact person listed in the portal. Acceptable forms of documentation requested from providers include support for total patient encounters, discharges, acute Medicaid days, charity care charges for which encounter variance is greater than 5%. Standard EHR reports supporting meaningful use adherence (such as exclusion documentation, EHR reports, etc.), EHR certification documentations, and other supporting documentations may also be requested. The attestation portal will provide a way for EPs or EHs to upload requested records via the portal when possible; however providers will be encouraged to enroll with secure Direct Secure Messaging service (DSM) as the preferable method to provide documentation. DMS does offer Voltage Secure Mail for those providers who do not have an acceptable secure method for supplying requested data. In addition, data sources to be used include MMIS claims and encounter data, utilization data, auditable financial

and accounting reports, cost reports, NLR Microstrategy business intelligence reports, Research and Support User Interface, Certified HIT Product List and any opportunities to collaborate with associations.

6.2 Meaningful Use Audits

South Dakota has designated CMS to conduct EH Meaningful Use auditing for dual-eligible and Medicaid hospitals. The Division of Medical Services has contracted with an outside vendor to conduct MU audits of EPs. Providers that have received payment for MU will undergo the same risk assessment as with AIU with an additional risk assessment for MU. MU providers will be assigned a risk category based on the AIU risks score and/or the MU risk score. MU audits will encompass all the components of the attestations (e.g. provider eligibility, patient volumes, CEHRT verification, etc.) as well as auditing all of the MU measures and CQMs. The provider will receive a letter from the MU auditor informing them of the audit and requesting additional documentation as required for the audit. The audit findings will be submitted to DMS for determination of the subsequent action to take place.

6.3 Risk Assessment Approach

Risk profiles have been established to efficiently identify potential audit targets and to assess which eligibility, AIU, and MU measures are likely to be subject to incorrect information. A combination of primary and secondary, and alternate data validation approaches will be applied.

The risk of waste, fraud, and abuse is low when provider's attestations can be verified using data sources such as claims data, cost reports, and other reports. A medium risk level involves attestations submitted by providers that are not easily verified. A high risk for improper payment, waste, fraud, or abuse occurs for provider attestations where reports or benchmarks to verify attestations are unavailable or difficult. Examples of high risk elements include encounters or discharges in the denominator for total patient volumes excluding Medicaid patients. Lack of providing documentation during attestation would raise the risk profile for audit.

6.2 Audit Selection Process

Risk scoring profiles will be utilized to identify providers who pose the highest risk to the South Dakota Medicaid EHR Incentive Program. Each provider receiving an incentive payment will be evaluated for risk factors which will result in a risk score.

When all providers are scored, they will be categorized into either a high, medium, or low risk category based on their final individual risk scores; a score of 0 – 7 will classify a provider in the low risk category; a score 8 – 13 will result in assignment to the medium risk category; and a score of 14 or more will classify a provider in the high risk category. All providers in the High Risk category will be subject to an audit, and if time and resources are available, at least 10% of the providers in the Medium Risk category and 5% of the providers in the Low Risk category will be subject to an audit. Providers in the Medium Risk and Low Risk categories will be selected via a random process to ensure all providers are equally candidates for an audit. In addition, any provider identified for a targeted audit during the pre-verification process will be flagged as an audit candidate. The actual number of audits conducted will be adjusted to ensure at least 10% of the providers are audited.

We are assigning risk criteria based on high, medium, and low risk factor values. The following pages list the risk factor table that will be utilized to develop each provider's risk score.

SD Medicaid EHR Incentive Risk Criteria Assessment

Risk Factor	Description	Low Criteria = 1	Medium Criteria = 2	High Criteria = 3
Percentage of the attested EP Medicaid patient encounter volume variance compared to the MMIS verified encounter volume	The risk associated with variance between the attested Medicaid encounters and the Medicaid encounters derived from actual Medicaid claims	The EP/Group's attested volume is less than or equal to +/- 5% of the verified MMIS volume	The EP/Group's attested volume is greater than or equal to 6% and less than or equal to 15% of the verified MMIS volume	The EP/Group's attested volume is greater than 15% of the verified MMIS volume
An EP/Group FQHC/RHC requires needy encounters (charity or sliding scale encounters) to achieve the minimum 30% patient encounter	The risk associated with verifying non-Medicaid encounters required to meet the 30% Medicaid encounter threshold	N/A	The FQHC/RHC EP/Group requires needy encounters to achieve the 30% encounter threshold	N/A
Pediatricians attested with less than 30% but 20% or more Medicaid encounter volume	The risk associated with attestations less than 30%	Pediatrician (or pediatrics group) encounter volume is greater than or equal to 20% and less than or equal to 29%	N/A	N/A
EP/Group or EH including Out of State Medicaid encounters as a portion of the attested Medicaid encounter volume	The risk associated with verifying out of state Medicaid encounters	EP/Group or EH has included Out of State Medicaid encounters totaling 25% or more of the attested Medicaid patient volume	N/A	N/A
An EP practicing in a FQHC/RHC attests as an individual	The risk of an individual in an FQHC which typically bills as the organization	N/A	N/A	An EP practicing in an FQHC/RHC attests as an individual

An EP/Group that typically bill via global codes (such as an obstetrician)	The risk associated with verifying Medicaid encounters that the EP for which does not submit claims	N/A	The EP/Group bills with global codes	N/A
The EP/EH has been selected for another Medicaid audit resulting in recoupment of funds	The risk associated with providers having a past history of adverse audit findings	The EP/EH was the subject of another Medicaid audit resulting in recoupment more than 5 years ago	The EP/EH was the subject of another Medicaid audit resulting in recoupment more than 3 years ago but less than 5 years ago	The EP/EH was the subject of another Medicaid audit resulting in recoupment less than 3 years ago
Medicaid enrollment date	The risk associated with EP/EHs who are new to the program and are a greater risk of non-compliance	The EP/EH has been enrolled in Medicaid over 2 years	The EP/EH has been enrolled in Medicaid over 1 year but less than 2 years	The EP/EH has been enrolled in Medicaid 1 year or less
Terminated Medicaid participation	The risk associated with a provider who has left the Medicaid program since receiving an incentive payment	N/A	N/A	The EP/EH has been terminated or has voluntarily left from the Medicaid program since receiving an incentive payment
EP/EH engaged the services of the REC	The risk associated with an EP/EH attesting incorrectly	The EP/EH did not engage the REC for their attestation	N/A	N/A
An EP attests utilizing free CEHRT	The risk associated with an EP's commitment demonstrated by utilizing free CEHRT, as well as a possible lack of support by the vendor	N/A	An EP attested using a free CEHRT	N/A
Provider attested using the 2014 Flexibility Rule	The risk associated with an EP attesting using the Flexibility Rule	N/A	The EP attested using the 2014 Flexibility Rule	N/A

	inappropriately			
Percentage of the attested EH Medicaid patient encounter (inpatient discharges and emergency department encounters) compared to the MMIS verified encounter volume	The risk associated with variance between the attested Medicaid encounters and the Medicaid encounters derived from actual Medicaid claims	The EH's attested volume is less than or equal to +/- 5% of the verified MMIS volume	The EH's attested volume is greater than or equal to 6% and less than or equal to 15% of the verified MMIS volume	The EP/Group's attested volume is greater than 15% of the verified MMIS volume
EHS that use cost reports with less than a 4 year consecutive 12 month cost reporting period	The risk associated with having less than 4 years of data from cost reports to calculate the average growth rate portion of the incentive payment	Children's Hospital that attest using less than 4 years of cost report data	N/A	EH that attest using less than 4 years of cost report data
EH attests with charity care charges or uncompensated care charges not supported by cost reports		Charity care or uncompensated care charges not supported by cost reports	N/A	N/A

SD Medicaid EHR Meaningful Use Criteria Assessment

Risk Factor	Description	Low Criteria = 1	Medium Criteria = 2	High Criteria = 6
Reported Meaningful Use percentage variance as compared to the required threshold for the 10 core measures with percentage reporting	The risk associated with variance between the attested measure value and the required measure value	The attested measure percentage is greater than 5% for 3 or less core measures	The attested measure percentage is greater than 5% for 4 to 6 core measures	The attested measure percentage is greater than 5% for 7 or more core measures
An EP or EH claims an exclusion on 3 or more core and menu measures	The risk associated with verifying the qualifications for exclusions (6 core measures and 8 menu measures have exclusions)	N/A	The EP or EH claims 3 or more exclusions on core and menu measures	N/A
Individual group members attesting to different measures than the other group members	The risk associated with an individual EP group member reporting measure different than the majority of group attestation	EP attested to 1 measure not reported by other group members	EP attested to 2 or less measures not reported by other group members	EP attested to more than 2 measures not reported by other group members
EP attesting to a Public Health Measure not operative in the state	The risk of an EP attesting to meeting a non-functioning registry or taking the exclusion without sufficient documentation	EP attested with to non-functional registry with an exclusion	N/A	EP attested to meeting the requirements for a non-functioning registry

Meaningful Use Core and Menu measure audits primarily target measures with high control risk where verification data is available as described in Section 4.2., but all components will be reviewed during an audit.

DMS anticipates risk assessment review on an annual basis upon post- payment reviews and trend assessments, and will update the audit plan accordingly.

6.3 Initiate the Audit

The EPs chosen for audit will be notified via a letter sent via the email address noted in the EP's attestation. The letter will also contain the initial documentation requests. Please see Appendix D for a sample of the letter and initial documentation request. If we do not receive a response to the letter within 3 business days a call is made to the phone number/contact person listed in the attestation to confirm they have received the notification of the audit.

The initial list of requested documents is developed by the auditor reviewing the submitted attestation and existing documentation for support of the attestation as well as any measures that were identified during the risk assessment. The basis of each MU audit is the Post Payment MU Audit Checklist, shown in Exhibit E.

6.4 Conduct the Audit

As the requested documentation is received, the auditor continues reviewing the attestation and supporting documentation as prescribed in the audit checklist. The review process usually reveals the need for additional documentation; the auditor contacts the provider via email with subsequent documentation request and works with the practice to ensure the correct documentation is received.

If a desk review results in no adverse findings, then the provider is notified that audit has been completed with adverse findings. If the audit results in adverse findings or the documentation supplied by the provider is insufficient to complete the audit, a field audit may be conducted; but usually the auditor makes a recommendation to DMS for recoupment of the inactive funds. If a field audit is required, a formal audit letter will be sent to the provider, and the letter will include a request to schedule the field audit. During the field audit, staff will review and witness source of documentation, workflow, demonstration of system, and other relevant material. Field audits will not be restricted to just those items at issue discovered in the desk audit; all components of the attestation will be subject to review.

If an audit identifies overpayments, underpayments, or improper payments, the amount determined as an overpayment or improper payment will be recouped from the provider in accordance with existing procedures. Improper incentive payments are those made to an ineligible hospital or professional. DMS will issue the recoupment of funds notice, along with the summary page of audit findings to the provider. Repayment is recovered by check and due within 30 days of notification. EHR incentive funds recouped from providers will be identified on the CMS-64 as an adjustment in line 10B in accordance with EHR Incentive Payment Program specifics. Also, DMS will report quarterly recoupment amounts on the Quarterly RO Tool report submitted to CMS, as well as regular reporting procedures.

If abuse is detected, a notice to the provider is sent to recoup payment. If it is determined the abuse occurred due to the provider misunderstanding, then EHR Incentive Payment Program staff will follow up with providers with requests to repay, educate and recover the incentive payment. Providers have 30 days to appeal in writing even though DMS may adjust the overpayment amount after this date, based on additional documentation or provider correspondence.

If fraud is detected, the DMS will refer it to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office for further action, in accordance with existing DMS policies and the Memorandum of Understanding with the MFCU. MFCU will complete an independent review of possible provider fraud in the EHR Incentive Program. Upon determination by MFCU that there is a credible allegation of fraud, MFCU will request that DMS suspend all Medicaid payments to the provider and place the provider on pre-payment review. DMS will send a notice to the provider of its suspension of program payments within five days of taking such action without disclosing specific information concerning ongoing investigation.

DMS currently has plans to conduct an internal audit of agency management controls over the incentive payment eligibility determination and disbursement processes. The internal audit process will begin within 15 months of the first EHR incentive payments.

6.5 Reporting Audit Results to DMS

DMS will enter audit results into the CMS Research and Support User Interface (R&S UI). We will manually update the R&S UI with the intent to audit; the audit start date, and the audit completion date, along with the audit findings.

7. Documentation

DMS staff uses an AIU audit pre-payment checklist during the pre-payment verification.

Appendix A and B respectively illustrate the EP pre-payment verification worksheet and the EH pre-payment verification worksheet.

Appendix C Eligible Professional MU Procedure Checklist is the documentation used to perform pre-payment verification for Meaningful Use.

Appendix D is the letter templates used to notify an EP of an audit, as well as the letter templates for information requests and the outcomes of audits.

Appendix E is the Meaningful Use Audit checklist, used for all EP MU audits.

The contractor secured to conduct meaningful use audits on Medicaid providers will include an audit manager. The audit manager will provide the state with documentation and audit findings.

All documentation developed during an audit (audit work papers, provider submitted documentation, summary of audit findings, etc.) will be stored on the secure DMS network drive.

8. Timeline

Since the launch of the incentive program in December 2011, DMS has been performing pre-payment verifications of attestations submitted by providers. Post-payment audits for AIU payments began in the 4th quarter of FFY 2012. DMS began accepting meaningful use attestations in

fall 2012. Post-payment audits for meaningful use attestations began in the 1st quarter of FFY 2014. Post-payment audits of meaningful use will be conducted on a quarterly basis.

9. Evaluation and Reporting

Audit findings will be reviewed, analyzed and presented throughout the process and upon the quarterly audit completion. Findings will be assessed if there is a need to revise audit process and pools such as increasing or decreasing audit pools, addition of new audit elements and other categories. Findings will be used to identify areas of improvement and enhancement of provider educational materials. Audit procedures and documentation will be periodically updated.

SURS or Provider Reimbursements and Audits will report audit results and appeals via manual entry into the CMS HITECH Research and Support User Interface.

10. Provider Appeals

The existing DMS provider appeals process will allow providers to appeal the results of the audit determinations of the EHR incentive payment. The first recourse is to submit a request to the EHR program manager.

DMS has an informal process in the attestation portal for providers as an initial step to issue resolution. Eligible professionals and hospitals may respond to a DMS determination through an online issue resolution mechanism on the attestation portal. Provider can open an issue, submit and view the status of an issue.

Search for issues

Status: Open Search

Issue ID	Subject	Date	Status
10	New Issue	Mon, 12/12/2011 11:24	Open

Comments submitted successfully.

Comments:

Submit

Providers also have an opportunity to submit/upload information such as required documentation and track status. When a provider enters an issue on the EHR incentive portal, a notification is sent to the EHR incentive program staff who will work with the provider to resolve issues on a timely manner. For payments denied/pending status, staff will work with provider for issue resolution by requesting additional information or encouraging provider to correct and re-attest. If no resolution, then notification of the determination (including the basis for the decision) and information on a formal appeals process will be provided. Staff will work with the provider in an effort to resolve the issue prior to a formal appeals process.



Home	Contact Us	Change Password	Payments	My Issues	Add Issue	Logout
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South Dakota Medicaid EHR Incentive Payment Program

Welcome, Test EP
 Provider Type: Eligible Professional (EP)
 Status: Program Qualification Filed with EHR Status as Meaningful Use

Payment Year: Program Year:

Search for issues

Status

Issue ID	Subject	Date	Status
1	Test issue	Wed, 12/21/2011 10:42	Open

If the provider is not satisfied with the final determination of DMS, then the provider has the right to an appeals hearing to the Office of Administrative Hearings (OAH), an independent division, within 30 days of the notice of action. The Administrative Rules of South Dakota and the South Dakota Codified Law SDCL 28-6-6 and chapter 67:17:02.1-26 governs appeals practice and procedures before state administrative agencies.

A provider can file a notice of appeal:

- By writing a letter of explanation
- Request must state the reasons as to why the provider thinks the action is inaccurate and include any additional information, data, or documentation that supports the appeal. The requester's address with zip code and telephone number should also be included
- Be received by the agency and at the address indicated in the notice of action within 30 days of the date of the notice of action (date of notification letter)

If the provider has met the conditions of the appeal request, a formal appeal hearing will be scheduled. Appeals may be conducted in person or via telephone. South Dakota will be represented by an attorney from the Attorney General's Office, DSS/Division of Legal Services. The appeal hearing judge will issue a finding as a result of the appeal hearing.

If the provider disagrees with the findings of the appeal hearing, they may file an appeal with the South Dakota Circuit Court.

Appendix A. Eligible Professional Pre-payment Verification Worksheet

Provider Name:

Contact:

Provider #:

NPI:

Program Qualification Year:

Payment Year:

Status:

Procedure	Date and Note
REGISTRATION INFORMATION	
<input type="checkbox"/> Check if provider is enrolled in MMIS/SD Medx. If not enrolled, contact provider to direct them on how to become a South Dakota Medicaid provider. Refer to check for active status through their practice's contact such as the billing staff in your practice and to become a Medicaid provider with the South Dakota Division of Medical Services at 1-866-718-0084 or https://dss.sd.gov/sdmedx/includes/providers/becomeprovider/index.aspx ___ not enrolled ___ enrolled as a billing provider ___ enrolled as servicing provider: ___ assigning payment to self ___ assigning payment to billing NPI/TIN ___ other	
<input type="checkbox"/> Check if provider is eligible type: ___ Physician (MD,DO) pediatrician, ___ Nurse Practitioner, ___ Certified Nurse Midwife, ___ Dentist, ___ Physician assistant who furnishes services in a FQHC or RHC led by a physician assistant	
<input type="checkbox"/> Check applicant and payee NPI and TIN in portal MATCH in MMIS. Check if EFT information is available in MMIS If no match or no record, then pass on to enrollment/direct to NLR http://www.cms.gov/EHRIncentivePrograms/	
ELIGIBILITY	
<input type="checkbox"/> Check licensure information and effective dates ___ license current http://doh.sd.gov/boards/ ___ OIG exclusion list/list of excluded individuals/program integrity, MMIS provider file Excep 1 status http://exclusions.oig.hhs.gov	
<input type="checkbox"/> If provider practices in FQHC/RHC/Tribal , check the FQHC/RHC/Tribal clinic	
<input type="checkbox"/> If provider practices in FQHC/RHC/Tribal , check practices predominantly: FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year for provider- THIS IS A LOW RISK AND AUDITED POST-PAYMENT	
<input type="checkbox"/> If provider practices in FQHC/RHC/Tribal and if PA, check the <i>so led criteria</i> /documentation ___ PA is a primary provider ___ PA is the clinical/medical director of the FQHC/RHC ___ PA is an owner of the RHC	
<input type="checkbox"/> Non hospital based unless practicing in FQHC/RHC: 90% or more of services provided under POS 21 or 23	
<input type="checkbox"/> Verify reporting date and year for patient volume is in the previous calendar year (between Jan 1-Dec 31)	
<input type="checkbox"/> If attestation is for group: ___ Check clinic NPI if attesting for the group and ___ verify EP practices within the group; ___ verify all EPs in the group are using the same methodology for patient volume	
<input type="checkbox"/> If using patient panel method, check if EP is in Primary care case management	

<input type="checkbox"/>	Using the 90 day reporting period the provider submitted to meet the 30% patient volume (20% for pediatricians), pull a claims/encounter report. Compare the claims report to the submitted/attested Medicaid patient (numerator). If there is not a close match or a large variance exists, then request for further information from provider. If a provider includes patient volume from another state, then request Medicaid claims/encounters from the state with Provider NPI; Beginning date of reporting period; Ending date of reporting period; State contacts at the Medicaid HITECH TA website Verify if using group proxy or individual; FQHC/RHC/Tribal based for individuals with needs Work with CHAD for practice predominantly	
<input type="checkbox"/>	Verify clinic locations and indications for at least 50% of encounters in a setting with EHR	
	EHR STATUS	
<input type="checkbox"/>	Verification of the submitted CMS EHR Certification Number available at http://onc-chpl.force.com/ehrcert Check product list, ambulatory , certification status and certification number , product name	
<input type="checkbox"/>	Have documentation to adopt, implement, upgrade to a certified Electronic Health Record. Verification documents include a signed contract, user agreement, purchase order, receipt, or license agreement. A formal vendor letter should be accompanied by other forms of documentation showing financial or legal contractual commitment.	
<input type="checkbox"/>	If the provider is working with a REC, then work with HealthPOINT the and use REC resources as a secondary source of verification	Yes/No
	ATTESTATION	
<input type="checkbox"/>	Ensure all attestation information is completed, provider initialed, checked attestation terms and signed	
	ELIGIBILITY	
	<input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible Approver Initials: _____	
	PAYMENT	
<input type="checkbox"/>	If first year payment, check no previous year payment and no duplicate payments exists for provider that is using certified EHR/demonstrating AIU - 1 st year; must start by 2016	
<input type="checkbox"/>	Payments for a maximum of six years, no duplication payments	
<input type="checkbox"/>	___ non-pediatrician with at least 30% patient volume: ___first year payment=\$21, ___ pediatrician with 20-29% patient volume: ___first year payment=\$14,167 ___	
<input type="checkbox"/>	No provider begins receiving payments after 2016 and payments end by 2021	
<input type="checkbox"/>	Check for duplicate payment request. If duplicate payment request is successful, then approve for payment.	
<input type="checkbox"/>	If duplicate payment request fails, notify provider	
<input type="checkbox"/>	Approve for payment; notify through portal, once payment is locked, portal sends payment requests to MMIS. Note: payment must be made within 4-6 weeks after eligibility verification. Payments and remits sent to provider. Update amount of payment on portal. Note timing	
<input type="checkbox"/>	Track incentive payments and codes	

Appendix B. Eligible Hospital Pre-payment Verification Worksheet

Hospital Name:

Provider #:

NPI:

CCN:

Program Qualification Year:

Payment Year:

Status:

	PROCEDURE	DATE and NOTES
	REGISTRATION INFORMATION	
<input type="checkbox"/>	Check if provider is enrolled in MMIS/SD Medx. If not enrolled, contact provider to direct them on how to become a South Dakota Medicaid Provider. Direct to check for active status by logging into SD MEDX at https://dss.sd.gov/sdmedx/login/login.aspx and become a Medicaid provider by enrolling with the South Dakota Division of Medical Services at 1-866-718-0084 or https://dss.sd.gov/sdmedx/includes/providers/becomeprovider/index.aspx ___not enrolled, ___enrolled as a billing provider ___enrolled as servicing provider:	
<input type="checkbox"/>	Verify eligible type with the CMS Certification Number ending in ____ 0001 – 0879, ____ 1300-1399 ACH/CAH ____ 3300-3399 Children's and ACH ALOS of <=25 days	
<input type="checkbox"/>	Check applicant and payee NPI and TIN in portal MATCH in MMIS. If no match or no record, then pass on to enrollment/direct to NLR ___EFT information present in MMIS	
<input type="checkbox"/>	In good standing ___OIG exclusion list/list of excluded entities/program integrity ___currently on prepayment review, the Provider File on MMIS indicator EXCP (Exception)=1	
	ELIGIBILITY	
<input type="checkbox"/>	Verify reporting date and year for patient volume is in the previous fiscal year (between Oct 1-Sept 30)	
<input type="checkbox"/>	Using the 90 day reporting period the provider submitted to meet the 10% Medicaid patient volume except for CCHC or other children's hospital, pull a claims/encounter report. Compare the claims report to the submitted/attested Medicaid patient (numerator). If there is not a close match or a large variance exists, then request for further information from provider. If a provider includes patient volume from another state, then request Medicaid claims/encounters from the state with Provider NPI; Beginning date of reporting period; Ending date of reporting period; State contacts at the Medicaid HITECH TA website Patient volume is calculated using the total Medicaid patient encounters in any representative continuous 90 day period in the numerator and the total patient encounters in that same 90 day period in the preceding fiscal year. <ul style="list-style-type: none"> • Hospital encounters for calculating patient volume include services rendered to an individual where Medicaid paid for part or all of the inpatient discharges and emergency department services • The emergency department must be part of the hospital under the qualifying CMS Certification Number • Children's Health Insurance Program recipients must not be included <div style="text-align: center;"> $\frac{\text{Total Medicaid inpatient discharges + emergency department encounters in any representative continuous 90 day period in the preceding fiscal year}}{\text{Total patient inpatient discharges + emergency department encounters in that same 90 day period}}$ </div>	
<input type="checkbox"/>	Verify date of the base reporting year and timing	
<input type="checkbox"/>	Verify total discharges, hospital charges, charity care charges, Medicaid and hospital inpatients day's data of the Medicaid cost report and compare with the pre-calculated sheet. Data may be from the CMS Form 2552-90 or 2552-10 revised cost reports for 2011 or 2012. Use new CMS Form 2552-10 as soon as available. If data is not available, request auditable data from the hospital. If using 2552-90, ask for charity care data auditable documentation to be submitted by the hospital. An "auditors report" for charity care data for CAH an option? <ul style="list-style-type: none"> • Ensure observation days such as nursery, psych and rehab days are excluded. Nursery bed days may not be included in the 	

	<p>numerator or denominator for acute inpatient /hospital bed days. Note: in cases of observation days provided at a higher acute care level, then they can be included. In addition, DSH hospitals may use the DSH numbers by taking out the unpaid days</p> <ul style="list-style-type: none"> • Determine if Medicaid only or dual eligible hospital. For dual-eligible hospitals, acute inpatient bed days in the numerator for patients where Medicare Part A or Medicare Advantage under Part C was the primary payer may not be included • Verify meaningful use measures for eligible hospitals attesting after January 1, 2013. Request for EHR outputs, ancillary, financial and accounting records as needed. • Use C5 and D17 • Exception: new/merged/split hospital with < 4 year data, handle as an exception. Options are to wait, or to move forward with another data source. Communicate with hospital the process and that payments may be lower than anticipated. Reconcile payment amounts. 	
<input type="checkbox"/>	<p>Accurate calculation of payments, calculate and verify. Year 1 payment at 40%, year 2 at 40%, year 3 at 20% of aggregate EHR amount; Year 2 and 3 payments reconcile if necessary</p>	
	EHR STATUS	
<input type="checkbox"/>	Verify the submitted CMS EHR Certification Number available at http://onc-chpl.force.com/ehrcert	
<input type="checkbox"/>	Have documentation to adopt, implement, upgrade to a certified Electronic Health Record. Verification documents include a signed contract, user agreement, purchase order, receipt, or license agreement. A formal vendor letter should be accompanied by other forms of documentation showing financial or legal contractual commitment.	
<input type="checkbox"/>		
	ATTESTATION	
<input type="checkbox"/>	Ensure all attestation information is completed, provider initialed, checked attestation terms and signed	
	ELIGIBILITY	
	<input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible Approver Initials: _____	
	PAYMENT	
<input type="checkbox"/>	If first year payment, no previous year payment and no duplicates for provider that is using certified EHR/demonstrating AIU	
<input type="checkbox"/>	Payments for a maximum of three years. If first year payment, verify amount of payment; If subsequent years payment, verify amount and count must start by 2016 and consecutive from 2016-2021	
<input type="checkbox"/>	No provider begins receiving payments after 2016 and payments end by 2021, participation for payments after 2016 is consecutive	
<input type="checkbox"/>	Check for duplicate payment request. If duplicate payment request is successful, then approve for payment else notify provider	
<input type="checkbox"/>	Approve for payment; notify through portal, once payment is locked, portal sends payment requests to MMIS. Note: payment must be made within 4-6 weeks after eligibility verification. Payments and remits sent to provider. Update amount of payment on portal. Note timing	
<input type="checkbox"/>	Track incentive payments and codes	

Appendix C. Eligible Professional Pre-Payment MU Procedure Checklist
ELIGIBLE PROFESSIONAL Pre-Payment MU PROCEDURE CHECKLIST

Provider:

NPI:

Program Qualification Year:

Payment Year:

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/Calculations	Conclusion	W/P Ref	Comments/Follow-Up
1. EP must be one of the following permissible professional types: <ul style="list-style-type: none"> Physician Dentist Certified Nurse Midwife Nurse Practitioner Physician Assistant (PA) 	Check if provider is enrolled in MMIS/SD Medx. If not enrolled, contact provider to direct them on how to become a South Dakota Medicaid provider. Refer to check for active status through their practice's contact such as the billing staff in your practice and to become a Medicaid provider with the South Dakota Division of Medical Services at 1-866-718-0084 or https://dss.sd.gov/sdmedx/includes/providers/becomeprovider assigning payment to self. ___not enrolled, ___enrolled as a billing provider ___enrolled as servicing provider: ___assigning payment to self ___assigning payment to billing NPI/TIN ___other	<ul style="list-style-type: none"> NLR File SLR File MMIS Provider Data 	EP Type per NLR: EP Type per SLR: EP Type per MMIS: <input type="checkbox"/> Physician <input type="checkbox"/> Dentist <input type="checkbox"/> Certified Nurse Midwife <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant	If the provider type cannot be verified as one of the permissible professional types, the EP is not eligible <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible		
2. EP has not participated in both the Medicaid and Medicare EHR Incentive Program	Medicaid and Medicare Duplication Payment Verification: 2.1 If the SLR processes D16 transactions and only releases an EP for payment upon confirmation from the NLR that no payments were processed for the EP for the payment year then no further action is necessary. 2.2 Review the National Level Repository (NLR) and verify that the EP is not participating in both the Medicaid and Medicare EHR Incentive Programs EHR Incentive Programs from Multiple States Verification: 2.3 If the SLR processes D16 transactions and only releases an EP for payment upon confirmation from the NLR that no payments were processed for the EP for the payment year then no further action is necessary. 2.4 Review the NLR and determine if the EP is participating	<ul style="list-style-type: none"> SLR Data NLR MMIS Query of payments made to the EP during the applicable payment year 	EP Payment Amount(s): EP Payment Date(s):	If the EP has is participating in the Medicare EHR Incentive Program or if the EP is participating in the Program in another State or has received an incentive payment during the payment year, the EP is not eligible. <input type="checkbox"/> Eligible		

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/ Calculations	Conclusion	W/P Ref	Comments/Follow-Up
	<p>in more than one States' EHR Incentive Program</p> <p>2.5 Review payments made to the EP (using the EP's NPI and TIN) and confirm that only no incentive payments have been made to the EP during the applicable payment year</p>			<input type="checkbox"/> Not Eligible		
3. EP must be licensed to practice in the State	<p>Medical License Verification:</p> <p>3.1 Refer to the State Medical Board's website and verify that the EP is a licensed medical EP in the state and that the license is active</p>	<ul style="list-style-type: none"> Board Certification website EP's name, as recorded on the State Medical Board website 	<p>License Number:</p> <p>Expiration Date:</p>	<p>If the EP does not have an active medical license in the State for the applicable EP type, the EP is not eligible</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not Eligible</p>		
4. EP must be a Medicaid provider in the State	<p>Medicaid Provider Verification:</p> <p>4.1 Verify in the MMIS that the EP is a current Medicaid provider in the State</p> <p>4.2 Check applicant and payee NPI and TIN in portal MATCH in MMIS. Check if EFT information is available in MMIS. If no match or no record, then pass on to enrollment/direct to NLR http://www.cms.gov/EHRIncentivePrograms/</p>	<ul style="list-style-type: none"> MMIS 	<p>EP Eligible Medicaid Provider</p> <p>Effective Date:</p>	<p>If the EP is not a current Medicaid provider in the State, the EP is not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not Eligible</p>		
5. EP cannot be sanctioned or otherwise deemed ineligible to receive payments from the State	<p>Sanctions Verification:</p> <p>5.1 Verify in the MMIS, on the State Medical Board website, and with the State Health & Human Services Office of the Inspector General (OIG):</p> <p>a) The EP is not currently sanctioned</p> <p>b) The EP has not had previous sanctions</p> <p>c) The EP has not had past issues of Medicaid or Medicare claims fraud</p>	<ul style="list-style-type: none"> MMIS State Medical Board State HHS OIG 	<p>Sanctions per MMIS:</p> <p>Medical Board Sanctions:</p> <p>OIG Sanctions:</p>	<p>If the EP has current sanctions, the EP is not eligible.</p> <p>If the EP has previous, relevant sanctions or past issues of Medicaid or Medicare claims fraud, the EP should be flagged for an onsite post-payment audit.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not Eligible</p> <p><input type="checkbox"/> Flag for Onsite</p>		

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/Calculations	Conclusion	W/P Ref	Comments/Follow-Up
				Post-Payment Audit (Add the EP to Appendix H: MU Audit Results Template)		
6. EP must practice in a PA-led FQHC or RHC if s/he is a PA	PA-Led Verification: 6.1 If the EP type reported by the EP is a PA, request and review documentation from the EP to verify that the EP practices in a FQHC or RHC that is so led by a PA that is one the following: a) the primary EP in the clinic b) is a clinical or medical director at the clinical site of practice c) an owner of the RHC	<ul style="list-style-type: none"> EP-submitted documentation supporting that the FQHC or RHC is led by a PA with signed attestations from Director/ Supervisor (A letter or document verifying PA led) 	Based on the documentation, document the criteria that met the "so led" requirement:	If the State is unable to verify that the EP practices in a PA-led FQHC or RHC, the EP is not eligible <input type="checkbox"/> Eligible and Supporting Documentation has been submitted. <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Applicable		
7. EP must not be hospital-based (more than 10% of his/her Medicaid claims must be outside an inpatient hospital or emergency room setting - POS 21 and 23) Note: Beginning with program year 2013 CMS established an administrative process for EP's determined as hospital-based to claim an exception and present documentation to obtain a nonhospital-based determination in accordance with §495.5.	Hospital Based Verification: 7.1 Query MMIS for claims or encounters paid by place of service for the EP during the calendar year preceding the payment year and subtotal the Medicaid claim payment by place of service code 7.2 Add the total of claim payments in POS 21 and POS 23 and verify that the total claims in POS 21 and POS 23 is not more than 90% of the total Medicaid claims in the query	<ul style="list-style-type: none"> MMIS 	Medicaid Claims POS 21: Medicaid Claims POS 23: Total Medicaid Claims: Percentage of Medicaid Claims POS 21 and 23 to total Medicaid Claims:	If the EP is hospital based and does not meet the hospital-based exclusion, the EP is not eligible <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible <input type="checkbox"/> Not Applicable		
8. EPs must have more than 50% of his/her total patient encounters occur at a FQHC or RHC over a six month period* to be considered as practicing	Practice Predominately if the EP works in a FQHC or RHC Verification: 8.1 Obtain and review documentation from the EP to support total patient encounters and total patient encounters that occurred at the FQHC or RHC over a six month period either during the prior calendar year or	<ul style="list-style-type: none"> SLR File EP-submitted documentation supporting total patient encounters and 	Total patient encounters per the SLR: Total patient	If the EP's patient encounters reported per the attestation were not supported by the documentation		

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/ Calculations	Conclusion	W/P Ref	Comments/Follow-Up
<p>predominantly in a FQHC or RHC.</p> <p>*The timeframes for the 6 month period are: Program year 2011- 2012: <ul style="list-style-type: none"> prior calendar year Program years 2013 and beyond: <ul style="list-style-type: none"> selected by the EP either 1) prior calendar year or 2) the most recent 12 months prior to the attestation. </p> <p><i>Note: Indian Health Services are considered FQHCs for the purpose of this Audit Program.</i></p>	<p>most recent 12 months prior to the attestation depending on the rule which applies to the attestation being audited.</p> <p>8.2 Compare the patient encounters at the FQHC or RHC and total patient encounters per the SLR to the documentation that was provided by the EP. Determine if the EP's attestation is reasonably consistent (for example, +/- 15%) with the documentation provided by the EP.</p> <p>8.3 Verify that the EP's patient encounters at the FQHC or RHC per the verified documentation was at least 50% of his/her total patient encounters</p>	<p>patient encounters at a FQHC or RHC during the prior calendar year with signed attestations from Director/ Supervisor</p>	<p>encounters in a FQHC or RHC:</p> <p>Percent of total patient encounters in a FQHC/RHC to total patient encounters:</p> <p>Variance:</p>	<p>provided, the EP is not eligible.</p> <p>If the documentation does not meet the practice predominately threshold, the EP is not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not Eligible</p> <p><input type="checkbox"/> Not Applicable</p>		
<p>9. EP must have at least 30% Medicaid patient volume (or 20% for pediatricians) for a consecutive 90 day period that varies depending on the program year the EP attested. If the program year is 2011 and 2012 then the 90 days is during the prior calendar year. If the program year is 2013 or beyond the EP may choose between the prior calendar year and 12 months prior to the attestation for the 90 day period.</p> <p><i>Note: Beginning with program year 2013, the definition of encounter was redefined to include encounters for patients enrolled in Medicaid as well as Title XXI-funded Medicaid expansion encounters.</i></p> <p><i>Refer to Appendix G, Exhibit 1: MU EP Patient Volume Methodologies for additional</i></p>	<p>Numerator for Patient Volume Verification:</p> <p>9.1 Review the SLR attestation data for the patient volume reporting period and the program year, to determine if the EP has attested to an applicable timeframe according to the final rule for their attestation.</p> <p>9.2 Review the SLR registration data and the MMIS to determine if the EP is a pediatrician. If the EP is a pediatrician, the patient volume must be at least 20%; otherwise, the patient volume must be 30% for all other EP types.</p> <p>Numerator for Patient Volume Verification:</p> <p>9.3 Verify Medicaid patient volume numerator: Verify the numerator value used in the EP's calculation for the reporting period by validating Medicaid claim and/or encounter data, as applicable, with the MMIS.</p> <p>Reasonableness Test for Patient Volume Denominator:</p> <p>9.4 After verifying the Medicaid patient volume numerator in MMIS (see 8.2 and 8.3), assess the EP's patient volume denominator for reasonableness to determine if it looks relatively complete and if the time period is appropriate (e.g., if an EP submits that they had 30 Medicaid encounters and only 100 total encounters; while the 30 in the numerator may very well be accurate, consider if it seem likely that an EP would have only 100 encounters in a 90 day period)</p> <p>9.5 Verify that the EP met the minimum patient volume based on the supported numerator & reasonableness</p>	<ul style="list-style-type: none"> MMIS Claims File SLR File MMIS Member File MMIS Provider File EP-submitted supporting documents and records with signed attestations from Director/ Supervisor All Payer Claims Database 	<p>EP Type:</p> <p>Patient Volume Percentage Requirement:</p> <p>Reporting Period:</p> <p>EP Attestation Numerator:</p> <p>Calculated Numerator per State:</p> <p>EP Attestation Denominator:</p> <p>Calculated Denominator per State:</p> <p>%Variance:</p>	<p>If the EP's denominator does not pass the reasonableness test or if the denominator could not be verified based on the EP's submitted documentation, the EP is not eligible.</p> <p><input type="checkbox"/> Reasonableness Test Passed</p> <p><input type="checkbox"/> Eligible – Supported by Documentation</p> <p><input type="checkbox"/> Not Eligible</p>		

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/ Calculations	Conclusion	W/P Ref	Comments/Follow-Up
<i>guidance and acceptable patient volume equations, including calculations for clinics or group practices</i>	<p>determination of the denominator</p> <p>Denominator for Patient Volume Verification (refer to the Note in the Procedures/ Results section above):</p> <p>9.6 Verify the EP's calculation of the denominator with the All Payer Claims Database, or</p> <p>9.7 Obtain documentation from the EP to support his/her total patient encounters during the applicable incentive payment year and review the documentation for reasonableness (e.g., looks relatively complete, time period is appropriate, etc.)</p> <p>9.8 Compare the patient volume percentage per the SLR to the documentation that was provided by the EP. Determine if the EP's attestation is reasonably consistent (for example, +/- 15%) with the documentation provided by the EP</p> <p>9.9 Verify that the EP met the minimum patient volume based on the supported numerator & denominator</p>					
<p>10. If the EP is practicing predominantly in a FQHC or RHC, the EP must have at least a 30% needy individual patient volume for a consecutive 90 day period that varies depending on the program year the EP attested. If the program year is 2011 and 2012 then the 90 days is during the prior calendar year. If the program year is 2013 or beyond the EP may choose between the prior calendar year and 12 months prior to the attestation for the 90 day period.</p> <p>Note: Beginning with program year 2013, the definition of encounter was redefined to include encounters for patients enrolled in Medicaid as well as Title XXI-funded Medicaid expansion encounters.</p> <p><i>Refer to Appendix G, Exhibit 1:</i></p>	<p>Patient Volume Reporting Period Verification:</p> <p>10.1 Review the SLR attestation data for the patient volume reporting period and the program year, to determine if the EP has attested to an applicable timeframe according to the final rule for their attestation.</p> <p>Numerator for Needy Patient Volume Verification:</p> <p>10.2 Verify the Medicaid and CHIP portions of the numerator used in the EP's calculation for the reporting period by verifying Medicaid and CHIP claim payments, Medicaid and CHIP enrollment data, as applicable, with the MMIS</p> <p>10.3 Obtain and review documentation from the EP to support the uncompensated care and sliding scale needy patient volume</p> <p>Denominator for Needy Patient Volume Verification:</p> <p>10.4 Review documentation submitted for the numerator for their contribution to the denominator:</p> <p>a) Review MMIS for Medicaid and CHIP claim payments and/or encounter data</p> <p>b) Review documentation from the EP to support the uncompensated care and sliding scale encounters</p> <p>10.5 Verify the Medicare and private-pay portions of the denominator with in the All Payer Claims Database, or obtain and review documentation from the EP for all private-pay encounters</p> <p>Calculation of Need Patient Volume:</p> <p>10.6 Compare the patient volume percentage per the SLR to</p>	<ul style="list-style-type: none"> • EP attestation • MMIS Claims File • MMIS Member File • EP-submitted supporting documents and records with signed attestations from Director/ Supervisor • All Payer All Claims (APCD) Database 	<p>Patient Volume Percentage Requirement:</p> <p>Reporting Period:</p> <p>EP Attestation Numerator:</p> <p>Medicaid/CHIP value:</p> <p>Uncompensated/ Sliding Scale Value:</p> <p>EP Attestation Denominator:</p> <p>Medicaid/CHIP value:</p> <p>Uncompensated/ Sliding Scale Value:</p>	<p>If the State's numerator calculation differs from the EP's calculated numerator, the EP is ineligible</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not eligible</p> <p><input type="checkbox"/> Not Applicable</p> <p>If the State's denominator calculation differs from the EP's calculated denominator, the EP is not eligible</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not eligible</p>		

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/ Calculations	Conclusion	W/P Ref	Comments/Follow-Up
<i>MU EP Patient Volume Methodologies for additional guidance and acceptable patient volume equations, including calculations for clinics or group practices</i>	<p>the documentation that was provided by the EP. Determine if the EP's attestation is reasonably consistent (for example, +/- 15%) with the documentation provided by the EP</p> <p>10.7 Compare the State's needy patient volume calculation to the EP's attested patient volume value and determine whether the percentage is reasonably consistent (for example, +/- 15%)</p>		<p>Private Pay Value:</p> <p>Variance:</p>			
<p>11. If the EP is attesting as part of a group practice/clinic, all EPs in the group must use the same methodology for the payment year; they must use the entire practice's patient volume and not limit it in any way.</p> <p><i>Refer to Appendix G, Exhibit 1: MU EP Patient Volume Methodologies for additional guidance and acceptable patient volume equations, including calculations for clinics or group practices</i></p>	<p>Group Calculation Verification:</p> <p>11.1 Review EP attestations to determine that all EPs attesting as part of a group practice/clinic are attesting using the same methodology for the payment year</p> <p>Group Patient Encounters Verification:</p> <p>11.2 Review NPI or TIN provider used to attest their group volume and compare it to the provider data in the MMIS or if necessary, employment contract to ensure the EP was an active member of the practice/clinic during the attestation.</p> <p>11.3 Review clinic submitted supporting documentation claims data supporting the group patient volume. Validate that the practice/clinic is the billing NPI, that the data was not limited, and includes only those encounters associated with the clinic or group practice.</p>	<ul style="list-style-type: none"> • SLR File • MMIS Claims File • MMIS Provider File • EP-submitted supporting documents with signed attestations from Director/ Supervisor 	<p>Calculation used:</p> <p>Time Frame for Calculation:</p> <p>Group NPI / TIN:</p>	<p>If the EP is within a group and the practice/clinic does not meet the patient volume requirements for group practice/clinic, they are not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not eligible</p> <p><input type="checkbox"/> Not Applicable</p>		
<p>12. For payment year 2013 and all subsequent payment years, EPs must have at least one clinical location used in the calculation of patient volume must have Certified EHR Technology</p>	<p>Patient Volume Provider Location Verification</p> <p>12.1 Obtain the supporting documentation that shows the location(s) where the EPs have certified EHR technology.</p> <p>12.2 Review EP attestations for location(s) with certified EHR technology used for patient volume and compare it with the location(s) given on the supporting documentation.</p>	<ul style="list-style-type: none"> • SLR File • EP-submitted documentation supporting that a location used for the patient volume has certified EHR technology 	<p>Practice Location(s)</p>	<p>If the location(s) used for patient volume that has certified EHR technology cannot be verified, the EP is not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not eligible</p> <p><input type="checkbox"/> Not Applicable</p>		
<p>13. Stage 1 Measures that require EP to attest to "all unique patients" in the denominator</p>	<p>Denominator Reasonableness Check:</p> <p>13.1 Obtain the denominator figures for core measures:</p> <ul style="list-style-type: none"> - EPCMU03: Maintain Problems List - EPCMU05: Active Medication List - EPCMU06: Medication Allergy List 	<ul style="list-style-type: none"> • SLR Data 	<p>EPCMU03:</p> <p>EPCMU05:</p> <p>EPCMU06:</p>	<p>If the denominators for core measures EPCMU03, EPCMU05 - EPCMU07, and if selected menu measures</p>		

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/ Calculations	Conclusion	W/P Ref	Comments/Follow-Up
	<ul style="list-style-type: none"> - EPCMU07: Record Demographics - EPMMU05: Patient Electronic Access - EPMMU06: Patient-Specific Education Resources <p>13.2 Compare the figures to which the EP attested for the each measure to verify that the same number was attested to for each measure.</p>		<p>EPCMU07:</p> <p>EPMMU05:</p> <p>EPMMU06:</p>	<p>EPMMU05 and EPMMU06 do not match, the EP is not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not eligible</p>		
14. Stage 2 Measures that require EP to attest to “all unique patients” in the denominator	<p>Denominator Reasonableness Check:</p> <p>14.1 Obtain the denominator figures for core measures:</p> <ul style="list-style-type: none"> - EPCMU03: Record Demographic - EPCMU04: Record Vital Signs - EPCMU07: Patient Electronic Access - EPCMU17: Use Secure Electronic Messaging - EPMMU04 Family Health History <p>Compare the figures to which the EP attested for the each measure to verify that the same number was attested to for each measure.</p>	<ul style="list-style-type: none"> • SLR Data 	<p>EPCMU03:</p> <p>EPCMU04:</p> <p>EPCMU07:</p> <p>EPCMU17:</p> <p>EPMMU04:</p>	<p>If the denominators for core measures EPCMU03, EPCMU04 - EPCMU07, EPCMU17, and if selected menu measure EPMMU04 does not match, the EP is not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not eligible</p>		
15. Multiple EHR systems	<p>15.1 Review the EP’s attestation for the number of certified EHR systems he/she currently uses.</p> <p>15.2 Review the number of certified EHR systems for EP groups falling under the same TIN.</p>	<ul style="list-style-type: none"> • SLR Data • 	<p>CCN# (system 1):</p> <p>CCN# (system 2):</p> <p>CCN# (system 3):</p>	<p>If the EP/EP group uses multiple certified EHR systems, the EP should be flagged for onsite post-payment audit.</p> <p><input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Flag for onsite Post-Payment Audit (Add the EP to Appendix H: MU Audit Results Template)</p>		
16. If applicable, the EP must adopt, implement, upgrade, or Meaningful User of certified EHR technology capable of demonstrating meaningful use.	<p>A/I/U/MU Verification:</p> <p>16.1 Obtain the EP’s CMS EHR Certification ID detailing its supporting components and verify that the Certification ID was issued from the ONC Certification Portal (ONC Certification Portal)</p> <p>16.2 Verify if the EP has changed its certified EHR Technology. If not, then no further action is necessary.</p> <p>16.3 If the certified EHR Technology has changed, obtain the supporting documentation that shows a legal or financial commitment to certified EHR technology, such as bill of</p>	<ul style="list-style-type: none"> • EHR Certification ID • ONC Portal • EP-submitted documentation supporting certified EHR system • Certified Product information 	<p>Certification ID:</p> <p>Payment Year:</p> <p>Verified Required Components:</p>	<p>If the A/I/U/MU of a certified EHR system cannot be verified, the EP is not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not Eligible</p>		

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/ Calculations	Conclusion	W/P Ref	Comments/Follow-Up
	<p>sale, receipts, contracts, maintenance agreements, licenses, canceled checks, or other documentation of the certified EHR technology.</p> <p>16.4 Review the supporting documentation to verify that the A/I/U/MU is a certified system, with all necessary components and if the EP's first payment year that it occurred during the 1st incentive payment year or prior.</p>			<input type="checkbox"/> N/A-- EP is attesting to MU and did not change their EHR		
17. Stage 1 Measures that require EPs to attest to a segment of their patient population	<p>17.1 Obtain the denominator figures for core measures</p> <ul style="list-style-type: none"> - EPCMU01: CPOE for Medication Orders - EPCMU08: Record Vital Signs - EPCMU09: Record Smoking Status <p>17.2 Verify that the denominator for each of the figures in 17.1 are less than or equal to the denominator figure of the measures in 13.1.</p>	<ul style="list-style-type: none"> • SLR Data 	<p>Unique patient denominator (as found in core measures EPCMU01, EPCMU08 - EPCMU09, and menu measure EPMMU04:</p> <p>:</p>	<p>If the EP has attested to denominators for EPCMU08 - EPCMU09, greater than the EP's attestation the denominators containing unique patient, the EP is not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not eligible</p>		
18. Stage 2 Measures that require EPs to attest to a segment of their patient population	<p>18.1 Obtain the denominator figures for core measures</p> <ul style="list-style-type: none"> - EPCMU01 CPOE for Medication, Laboratory, and Radiology Orders -EPCMU02: e-prescribing -EPCMU05: Record Smoking Status -EPCMU10: Clinical Lab Test Results -EPCMU12: Preventive Care -EPCMU14Medication Reconciliation -EPCMU15: Summary of Care -EPMMU03: Imaging Results <p>18.2 Verify that the denominator for each of the figures in 18.1 are less than or equal to the denominator figure of the measures in 14.1.</p>	<ul style="list-style-type: none"> • SLR Data 	<p>Unique patient denominator (as found in core measures EPCMU01, EPCMU02, EPCMU05, EPCMU10, EPCMU12, EPCMU14, EPCMU15, and menu measure EPMMU03:</p>	<p>If the EP has attested to denominators for EPCMU01, EPCMU02, EPCMU 05, EOCMU10, EOCMU 12, EPCMU 14, EPCMU18 and - EPMMU03, greater than the EP's attestation the denominators containing unique patient, the EP is not eligible.</p> <p><input type="checkbox"/> Eligible</p> <p><input type="checkbox"/> Not eligible</p>		

Eligibility Requirements	Pre-Payment Procedures/Registration Information	Data Source	Results/ Calculations	Conclusion	W/P Ref	Comments/Follow-Up
19. History of CMS non-compliance	19.1 Verify in the MMIS and State Health & Human Services Office of the Inspector General (OIG) that the EP is free of a history of non-compliance with CMS in the past five years.	<ul style="list-style-type: none"> • MMIS • State Health & Human Services Office of the Inspector General (OIG) 	Non-compliance issue #1: Non-compliance date #1: Non-compliance issue #2: Non-compliance date #2: Non-compliance issue #3: Non-compliance date #3:	If the EP has a history of CMS non-compliance, the EP should be flagged for onsite post-payment audit. <input type="checkbox"/> N/A <input type="checkbox"/> Flag for Onsite Post-Payment Audit (Add the EP to Appendix H: MU Audit Results Template)		

EP:

Based on the procedures performed, the EP (select one):

- ☐ is eligible
- ☐ is not eligible to receive an EHR incentive payment for the payment year
- ☐ is flagged for onsite post-payment audit.
- ☐ needs to submit additional supporting documentation, which has been requested, for further verification.

Follow up by (insert date): _____

Performed by: _____

Reviewed by: _____

Date: _____

Date: _____

Appendix D. MU Audit Letter Templates

Click here to enter a date.

Dr. Click here to enter Provider Name,

Please be advised that the <Click here to enter State Department or State Entity Name>, intends to perform an audit to review documentation supporting your attestation for <Click here to enter AIU or Stage of MU Attestation> of the Medicaid Electronic Health Record (EHR) Incentive Program. This email provides notification that the <2013> program year application for the provider referenced above has been randomly selected for post-payment audit.

CMS has set standards in the Federal Code of Federal Regulations 42, section 495 that Eligible Professionals (EPs) must meet in order to successfully demonstrate MU to continue receiving incentive payments under the Medicaid EHR Incentive Program. We are responsible for confirming that EPs enrolled in the incentive program are using certified EHR technology in this manner as part of our audit and oversight responsibilities. The Agency has contracted with XXXX to conduct these post payment audits.

Please see the attached document lists with instructions and explaining the documentation we are requesting to conduct the audit. The documentation should be relevant for the reporting periods for which you attested.

Patient Volume Reporting Period: Click here to enter Patient Volume Reporting Period date range xx/xx/xxxx – xx/xx/xxxx.

EHR Reporting Period: Click here to enter Insert EHR Reporting Period xx/xx/xxxx – xx/xx/xxxx.

Please be aware that after reviewing the contents of your documentation we may request additional documentation. The documentation should be provided to HealthTech Solutions through a secure electronic format. The documents can be sent by mail on an encrypted disc or encrypted USB flash drive, or by using the <Insert Name of States Direct Secure Messaging service (DSM) if applicable>. Providers can sign up for DSM by visiting [insert Direct website address in hyperlink if applicable]. The requested documentation can be sent by regular email only if it does **not** contain Protected Health Information (PHI).

Please provide the requested documentation by >Click here to enter a date in long form> to:

If you are using the Direct Secure Messaging service, please email to:
<Click here to enter Employee Direct Secure Messaging Email Address as a Hyperlink>.

The contracts between <State Entities> and XXXX contain a confidentiality of information clause that states, propriety information or data submitted by or pertaining to an organization cannot be released without the prior written consent of the organization. Furthermore, if any information contained within the records your organization submits to XXXX constitutes confidential information, as such terms are interpreted under the Freedom of Information Act (FOIA) (5 U.S.C. § 552) and applicable case law, XXXX will protect such information from release when requested under FOIA in accordance with the Department of Health and Human Services regulations (45 C.F.R. § 5.65 (c)).

A representative from the <State agency> may contact you after your documentation is submitted for follow up on your responses as necessary. If you have any questions or would like further detail about the review or the requested documentation, please contact [Click here to enter Employee Name](#) at [Click here to enter Employee Phone #.](#)

Thank you,

[Click here to enter Employee Name](#)

Electronic Health Records Auditor

[Click here to enter a date.](#)

Dr. [<Click here to enter Provider Name>](#),

Thank you for your documentation submission. As I am sure you are aware of, not all Meaningful Use measures were included in the previous request for documentation. This letter serves as notification that the documentation for all remaining measures is now being requested in order to complete your Medicaid EHR Incentive Program post-payment audit.

Please see the attached document lists with instructions and explaining the documentation we are requesting to complete the audit. The documentation should be relevant for the reporting periods for which you attested.

Patient Volume Reporting Period: [Click here to enter Volume Reporting Period date range xx/xx/xxxx – xx/xx/xxxx.](#)

EHR Reporting Period: [Click here to enter Insert EHR Reporting Period xx/xx/xxxx – xx/xx/xxxx.](#)

Please be aware that after reviewing the contents of your documentation we may request additional documentation. The documentation should be provided to XXXX through a secure electronic format. The documents can be sent by mail on an encrypted disc or encrypted USB flash drive, or by using the [<Insert Name of States Direct Secure Messaging service \(DSM\) in applicable>](#). Providers can sign up for DSM by visiting [\[insert Direct website address in hyperlink if applicable\]](#). The requested documentation can be sent by regular email only if it does **not** contain Protected Health Information (PHI).

Please provide the requested documentation by [Click here to enter a date in long form to:](#)

If you are using the Direct Secure Messaging service, please email to:

[<Click here to enter Employee Direct Secure Messaging Email Address as a Hyperlink>](#).

The contracts between State Entities and XXXX contain a confidentiality of information clause that states, propriety information or data submitted by or pertaining to an organization cannot be released without the prior written consent of the organization. Furthermore, if any information contained within the records your organization submits to XXXX constitutes confidential information, as such terms are interpreted under the Freedom of Information Act (FOIA) (5 U.S.C. § 552) and applicable case law, XXXX will protect such information from release when requested under FOIA in accordance with the Department of Health and Human Services regulations (45 C.F.R. § 5.65 (c)).

A representative from the [<State agency>](#) may contact you after your documentation is submitted for follow up on your responses as necessary. If you have any questions or would like further detail about the review or the requested documentation, please contact [<Click here to enter Employee Name at Click here to enter Employee Phone #.>](#)

Thank you,

[Click here to enter Employee Name](#)
Electronic Health Records Auditor

<Date>

Dear <provider Name>

The South Dakota Department of Social Services would like to thank you for your cooperation during the 201X Electronic Health Record incentive payment audit recently performed. Based on the results of the audit:

-
- No discrepancies were noted; no further action is needed at this time.
-

If you have any questions or would like further detail about the results of your audit or the appeals process, please contact <auditor name> at (auditor phone number).

Again, we appreciate your cooperation.

Thank you,

<auditor name>

Electronic Health Records Auditor

Provider/Group Name
NPI Number
Address Line 1
Address Line 2
City, State, ZIP

Subject: **EHR Provider Incentive Payment
Post-Payment Audit
Audit Findings and Appeal Process**

date

To Whom It May Concern:

The South Dakota Provider Incentive Program conducted a review of documentation submitted as a part of the EHR Provider Incentive Payment Program. **The audit has resulted in the following adverse findings:**

□

The South Dakota Department of Social Services, Division of Medicaid Services will perform audits to validate application information and provider activities necessary to be eligible for this incentive program. 42 CFR 495.332 and 495.366 of the Health Information Technology for Economic and Clinical Health (HITECH) Act mandates that States must have an annual process in place to assure payment incentives are not duplicated and supporting documentation is verified. Providers are required to maintain supporting data that verifies basic information to assure patient volume is correct. This supporting data must be maintained for six years.

If you are not satisfied with the final determination of DMS, then you have the right to an appeals hearing to the Office of Administrative Hearings (OAH), an independent division, within 30 days of the notice of action. The Administrative Rules of South Dakota and the South Dakota Codified Law SDCL 28-6-6 and chapter 67:17:02.1-26 governs appeals practice and procedures before state administrative agencies.

You can file a notice of appeal:

- By writing a letter of explanation
- Request must state the reasons as to why the provider thinks the action is inaccurate and include any additional information, data, or documentation that supports the appeal. The requester's address with zip code and telephone number should also be included
- Be received by the agency and at the address indicated in the notice of action within 30 days of the date of the notice of action (date of notification letter)

If the provider has met the conditions of the appeal request, a formal appeal hearing will be scheduled. Appeals may be conducted in person or via telephone. South Dakota will be represented by an attorney from the Attorney General's Office, DSS/Division of Legal Services. The appeal hearing judge will issue a finding as a result of the appeal hearing.

If we do not receive a notice of appeal within thirty (30) days the EHR Incentive Payment in the amount of _____ will be recouped by Division of Medicaid Services.

Attachment B

**STATE OF SOUTH DAKOTA
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES**

**Consultant Contract
For Consultant Services
Between**

State of South Dakota
Department of Social Services
DIVISION OF MEDICAL SERVICES
700 Governors Drive
Pierre, SD 57501-2291

Referred to as Consultant

Referred to as State

The State hereby enters into a contract for consultant services with the Consultant. While performing services hereunder, Consultant is an independent contractor and not an officer, agent, or employee of the State of South Dakota.

1. CONSULTANT'S South Dakota Vendor Number is .
2. PERIOD OF PERFORMANCE:
 - A. This Agreement shall be effective as of June 1, 2017 and shall end on May 31, 2018, unless sooner terminated pursuant to the terms hereof.
 - B. Agreement is exempt from the request for proposal process. 963_____
3. PROVISIONS:
 - A. The Purpose of this Consultant contract:
 1. Perform MU audits for modified stage 2 and stage 3 MU attestations.
 2. Does this agreement involve Protected Health Information (PHI)? YES (X) NO ()
If PHI is involved, a Business Associate Agreement must be attached and is fully incorporated herein as part of the agreement (refer to attachment) .
 3. The consultant will not use state equipment, supplies or facilities.
 - B. The Consultant agrees to perform the following services (add an attachment if needed.):
 - 1.
 - C. The State agrees to:
 - 1.
 2. Make payment for services upon satisfactory completion of services and receipt of bill. Payment will be in accordance with SDCL 5-26.
 3. Will the State pay Consultant expenses as a separate item?
YES () NO (X)
If YES, expenses submitted will be reimbursed as identified in this agreement.

D. The TOTAL CONTRACT AMOUNT will not exceed \$.

4. BILLING:

Consultant agrees to submit a bill for services within (30) days following the month in which services were provided. Consultant will prepare and submit a monthly bill for services. Consultant agrees to submit a final bill within 45 days of the contract end date to receive payment for completed services. If a final bill cannot be submitted in 45 days, then a written request for extension of time and explanation must be provided to the State.

5. TECHNICAL ASSISTANCE:

The State agrees to provide technical assistance regarding Department of Social Services rules, regulations and policies to the Consultant and to assist in the correction of problem areas identified by the State's monitoring activities.

6. LICENSING AND STANDARD COMPLIANCE:

The Consultant agrees to comply in full with all licensing and other standards required by Federal, State, County, City or Tribal statute, regulation or ordinance in which the service and/or care is provided for the duration of this agreement. The Consultant will maintain effective internal controls in managing the federal award. Liability resulting from noncompliance with licensing and other standards required by Federal, State, County, City or Tribal statute, regulation or ordinance or through the Consultant's failure to ensure the safety of all individuals served is assumed entirely by the Consultant.

7. ASSURANCE REQUIREMENTS:

The Consultant agrees to abide by all applicable provisions of the following: , Byrd Anti Lobbying Amendment (31 USC 1352), Executive orders 12549 and 12689 (Debarment and Suspension), Drug-Free Workplace, Executive Order 11246 Equal Employment Opportunity, Title VI of the Civil Rights Act of 1964, Title VIII of the Civil Rights Act of 1968, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Drug Abuse Office and Treatment Act of 1972, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Age Discrimination Act of 1975, Americans with Disabilities Act of 1990, Pro-Children Act of 1994, Hatch Act, Health Insurance Portability and Accountability Act (HIPAA) of 1996 as amended, Clean Air Act, Federal Water Pollution Control Act, Charitable Choice Provisions and Regulations, Equal Treatment for Faith-Based Religions at Title 28 Code of Federal Regulations Part 38, the Violence Against Women Reauthorization Act of 2013 and American Recovery and Reinvestment Act of 2009, as applicable.

8. RETENTION AND INSPECTION OF RECORDS:

The Consultant agrees to maintain or supervise the maintenance of records necessary for the proper and efficient operation of the program, including records and documents regarding applications, determination of eligibility (when applicable), the provision of services, administrative costs, statistical, fiscal, other records, and information necessary for reporting and accountability required by the State. The Consultant shall retain such records for a period of six years from the date of submission of the final expenditure report. If such records are under pending audit, the Consultant agrees to hold such records for a longer period upon notification from the State. The State, through any authorized representative, will have access to and the right to examine and copy all records, books, papers or documents related to services rendered under this Agreement. State Proprietary Information retained in Consultant's secondary and backup systems will remain fully subject to the obligations of confidentiality stated herein until such information is erased or destroyed in accordance with Consultant's established record retention policies.

All payments to the Consultant by the State are subject to site review and audit as prescribed and carried out by the State. Any over payment of this contract shall be returned to the State within thirty days after written notification to the Consultant.

9. WORK PRODUCT:

Consultant hereby acknowledges and agrees that all reports, plans, specifications, technical data, drawings, software system programs and documentation, procedures, files, operating instructions and procedures, source code(s) and documentation, including those necessary to upgrade and maintain the software program, State Proprietary Information, State Data, End User Data, Personal Health Information, and all information contained therein provided to the State by the Consultant in connection with its performance of service under this Contract shall belong to and is the property of the State and will not be used in any way by the Consultant without the written consent of the State.

Paper, reports, forms software programs, source code(s) and other materials which are a part of the work under this Contract will not be copyrighted without written approval of the State. In the unlikely event that any copyright does not fully belong to the State, the State none the less reserves a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and otherwise use, and to authorize others to use, any such work for government purposes.

Consultant agrees to return all information received from the State to State's custody upon the end of the term of this contract, unless otherwise agreed in a writing signed by both parties.

10. TERMINATION:

This contract may be terminated by either party hereto upon thirty (30) days written notice. In the event the Consultant breaches any of the terms or conditions hereof, this Contract may be terminated by the State for cause at any time, with or without notice. Upon termination of this agreement, all accounts and payments shall be processed according to financial arrangements set forth herein for services rendered to date of termination.

11. FUNDING:

This Contract depends upon the continued availability of appropriated funds and expenditure authority from the Legislature for this purpose. If for any reason the Legislature fails to appropriate funds or grant expenditure authority, or funds become unavailable by operation of the law or federal funds reduction, this Contract will be terminated by the State. Termination for any of these reasons is not a default by the State nor does it give rise to a claim against the State.

12. AMENDMENTS:

This Contract may not be assigned without the express prior written consent of the State. This Contract may not be amended except in writing, which writing shall be expressly identified as a part hereof, and be signed by an authorized representative of each of the parties hereto.

13. CONTROLLING LAW:

This Contract shall be governed by and construed in accordance with the laws of the State of South Dakota, without regard to any conflicts of law principles, decisional law, or statutory provision which would require or permit the application of another jurisdiction's substantive law. Venue for any lawsuit pertaining to or affecting this Agreement shall be resolved in the Circuit Court, Sixth Judicial Circuit, Hughes County, South Dakota.

14. SUPERCESSION:

All prior discussions, communications and representations concerning the subject matter of this Contract are superseded by the terms of this Contract, and except as specifically provided herein, this Contract constitutes the entire agreement with respect to the subject matter hereof.

15. IT STANDARDS:

Consultant warrants that the software and hardware developed or purchased for the state will be in compliance with the BIT Standards including but not limited to the standards for security, file naming conventions, executable module names, Job Control Language, systems software, and systems software release levels, temporary work areas, executable program size, forms management, network access, tape management, hosting requirements, administrative controls, and job stream procedures prior to the installation and acceptance of the final project. BIT standards can be found at <http://bit.sd.gov/standards/>.

16. SEVERABILITY:

In the event that any provision of this Contract shall be held unenforceable or invalid by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision of this contract, which shall remain in full force and effect.

17. NOTICE:

Any notice or other communication required under this Contract shall be in writing and sent to the address set forth above. Notices shall be given by and to the Division being contracted with on behalf of the State, and by the Consultant, or such authorized designees as either party may from time to time designate in writing. Notices or communications to or between the parties shall be deemed to have been delivered when mailed by first class mail, provided that notice of default or termination shall be sent by registered or certified mail, or, if personally delivered, when received by such party.

18. SUBCONTRACTORS:

The Consultant may not use subcontractors to perform the services described herein without express prior written consent from the State. The State reserves the right to reject any person from the contract presenting insufficient skills or inappropriate behavior.

The Consultant will include provisions in its subcontracts requiring its subcontractors to comply with the applicable provisions of this Contract, to indemnify the State, and to provide insurance coverage for the benefit of the State in a manner consistent with this Contract. The Consultant will cause its subcontractors, agents, and employees to comply with applicable federal, state and local laws, regulations, ordinances, guidelines, permits and requirements and will adopt such review and inspection procedures as are necessary to assure such compliance. The State, at its option, may require the vetting of any subcontractors. The Consultant is required to assist in this process as needed.

19. HOLD HARMLESS:

The Consultant agrees to hold harmless and indemnify the State of South Dakota, its officers, agents and employees, from and against any and all actions, suits, damages, liability or other proceedings which may arise as the result of performing services hereunder. This section does not require the Consultant to be responsible for or defend against claims or damages arising solely from errors or omissions of the State, its officers, agents or employees.

20. INSURANCE:

Before beginning work under this Contract, Consultant shall furnish the State with properly executed Certificates of Insurance which shall clearly evidence all insurance required in this Contract. The Consultant, at all times during the term of this Contract, shall obtain and maintain in force insurance coverage of the types and with the limits listed below. In the event a substantial change in insurance, issuance of a new policy, cancellation or nonrenewal of the policy, the Consultant agrees to provide immediate notice to the State and provide a new certificate of insurance showing continuous coverage in the amounts required. Consultant shall furnish copies of insurance policies if requested by the State.

A. Commercial General Liability Insurance:

Consultant shall maintain occurrence-based commercial general liability insurance or an equivalent form with a limit of not less than \$1,000,000 for each occurrence. If such insurance contains a general aggregate limit, it shall apply separately to this Contract or be no less than two times the occurrence limit.

B. Business Automobile Liability Insurance:

Consultant shall maintain business automobile liability insurance or an equivalent form with a limit of not less than \$500,000 for each accident. Such insurance shall include coverage for owned, hired, and non-owned vehicles.

C. Worker's Compensation Insurance:

Consultant shall procure and maintain Workers' Compensation and employers' liability insurance as required by South Dakota law.

D. Professional Liability Insurance:

Consultant agrees to procure and maintain professional liability insurance with a limit not less than \$1,000,000.

(Medical Health Professional shall maintain current general professional liability insurance with a limit of not less than one million dollars for each occurrence and three million dollars in the aggregate. Such insurance shall include South Dakota state employees as additional insureds in the event a claim, lawsuit, or other proceeding is filed against a state employee as a result of the services provided pursuant to this Contract. If insurance provided by Medical Health Professional is provided on a claim made basis, then Medical Health Professional shall provide "tail" coverage for a period of five years after the termination of coverage.)

21. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION:

Consultant certifies, by signing this agreement, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by the federal government or any state or local government department or agency. Consultant further agrees that it will immediately notify the State if during the term of this Contract either it or its principals become subject to debarment, suspension or ineligibility from participating in transactions by the federal government, or by any state or local government department or agency.

22. CONFLICT OF INTEREST:

Consultant agrees to establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal organizational conflict of interest, or personal gain as contemplated by SDCL 5-18A-17 through 5-18A-17.6. Any potential conflict of interest must be disclosed in writing. In the event of a conflict of interest, the Consultant expressly agrees to be bound by the conflict resolution process set forth in SDCL 5-18A-17 through 5-18A-17.6.

23. REPORTING PROVISION:

Consultant agrees to report to the State any event encountered in the course of performance of this Contract which results in injury to any person or property, or which may otherwise subject Consultant, or the State of South Dakota or its officers, agents or employees to liability. Consultant shall report any such event to the State immediately upon discovery.

Consultant's obligation under this section shall only be to report the occurrence of any event to the State and to make any other report provided for by their duties or applicable law. Consultant's obligation to report shall not require disclosure of any information subject to privilege or confidentiality under law (e.g., attorney-client communications). Reporting to the State under this section shall not excuse or satisfy any obligation of Consultant to report any event to law enforcement or other entities under the requirements of any applicable law.

24. CONFIDENTIALITY OF INFORMATION:

For the purpose of the sub-paragraph, "State Proprietary Information" shall include all information disclosed to the Consultant by the State. Consultant acknowledges that it shall have a duty to not disclose any State Proprietary Information to any third person for any reason without the express written permission of a State officer or employee with authority to authorize the disclosure. Consultant shall not: (i) disclose any State Proprietary Information to any third person unless otherwise specifically allowed under this contract; (ii) make

any use of State Proprietary Information except to exercise rights and perform obligations under this contract; (iii) make State Proprietary Information available to any of its employees, officers, agents or consultants except those who have agreed to obligations of confidentiality at least as strict as those set out in this contract and who have a need to know such information. Consultant is held to the same standard of care in guarding State Proprietary Information as it applies to its own confidential or proprietary information and materials of a similar nature, and no less than holding State Proprietary Information in the strictest confidence. Consultant shall protect confidentiality of the State's information from the time of receipt to the time that such information is either returned to the State or destroyed to the extent that it cannot be recalled or reproduced. State Proprietary Information shall not include information that (i) was in the public domain at the time it was disclosed to Consultant; (ii) was known to Consultant without restriction at the time of disclosure from the State; (iii) that is disclosed with the prior written approval of State's officers or employees having authority to disclose such information; (iv) was independently developed by Consultant without the benefit or influence of the State's information; (v) becomes known to Consultant without restriction from a source not connected to the State of South Dakota. State's Proprietary Information shall include names, social security numbers, employer numbers, addresses and all other data about applicants, employers or other clients to whom the State provides services of any kind. Consultant understands that this information is confidential and protected under applicable State law at SDCL 1-27-1.5, modified by SDCL 1-27-1.6, SDCL 28-1-29, SDCL 28-1-32, and SDCL 28-1-68 as applicable federal regulation and agrees to immediately notify the State if the information is disclosure, either intentionally or inadvertently. The parties mutually agree that neither of them shall disclose the contents of the contract except as required by applicable law or as necessary to carry out the terms of the contract or to enforce that party's rights under this contract. Consultant acknowledges that the State and its agencies are public entities and thus are bound by South Dakota open meetings and open records laws. It is therefore not a breach of this contract for the State to take any action that the State reasonably believes is necessary to comply with the South Dakota open records or open meetings laws. If work assignments performed in the course of this Agreement require additional security requirements or clearance, the Consultant will be required to undergo investigation.

25. AUTHORIZED SIGNATURES:

In witness hereto, the parties signify their agreement by affixing their signatures hereto.

_____ Consultant Signature	_____ Date
_____ State - DSS Division Director Lori Lawson	_____ Date
_____ State - DSS Chief Financial Officer Laurie Mikkonen	_____ Date
_____ State - DSS Cabinet Secretary Lynne A. Valenti	_____ Date

State Agency Coding:

CFDA #	_____	_____	_____	_____
Company	_____	_____	_____	_____
Account	_____	_____	_____	_____
Center Req	_____	_____	_____	_____
Center User	_____	_____	_____	_____
Dollar Total	_____	_____	_____	_____

DSS Program Contact Person _____
Phone _____

DSS Fiscal Contact Person Contract Accountant
Phone 605 773-3586

Consultant Program Contact Person _____
Phone _____

Consultant Fiscal Contact Person _____
Phone _____

Consultant Email Address _____

SDCL 1-24A-1 states that a copy of all consulting contracts shall be filed by the State agency with the State Auditor within five days after such contract is entered into and finally approved by the contracting parties. For further information about consulting contracts, see the State Auditor's policy handbook.

Attachment C

STATE OF SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES

Attachment C

Business Associate Agreement

1. Definitions

General definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

- (a) Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the Provider, Consultant or entity contracting with the State of South Dakota as set forth more fully in the Agreement this Business Associate Agreement is attached.
- (b) CFR. “CFR” shall mean the Code of Federal Regulations.
- (c) Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103, and in reference to the party to this agreement, shall mean South Dakota Department of Social Services.
- (d) Designated Record Set. “Designated Record Set” shall have the meaning given to such term in 45 CFR 164.501.
- (f) HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164 (Subparts A, C, D and E). More specifically, the “Privacy Rule” shall mean the regulations codified at 45 CFR Part 160 and Part 164 (Subparts A and E), and the “Security Rule” shall mean the regulations codified at 45 CFR Part 160 and Part 164 (Subparts A and C).
- (g) Protected Health Information. “Protected Health Information” or “PHI” shall mean the term as defined in 45 C.F.R. §160.103, and is limited to the Protected Health Information received from, or received or created on behalf of Covered Entity by Business Associate pursuant to performance of the Services under the Agreement.

2. Obligations and Activities of Business Associate

Business Associate agrees to:

- (a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

- (b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;
- (c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware within five (5) business days of receiving knowledge of such use, disclosure, breach, or security incident;
- (d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;
- (e) Make available protected health information in a designated record set to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR 164.524. Business associate shall cooperate with covered entity to fulfill all requests by individuals for access to the individual's protected health information that are approved by covered entity. If business associate receives a request from an individual for access to protected health information, business associate shall forward such request to covered entity within ten (10) business days. Covered entity shall be solely responsible for determining the scope of protected health information and Designated Record Set with respect to each request by an individual for access to protected health information;
- (f) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526. Within ten (10) business days following any such amendment or other measure, business associate shall provide written notice to covered entity confirming that business associate has made such amendments or other measures and containing any such information as may be necessary for covered entity to provide adequate notice to the individual in accordance with 45 CFR 164.526. Should business associate receive requests to amend protected health information from an individual, Business associate shall cooperate with covered entity to fulfill all requests by individuals for such amendments to the individual's protected health information that are approved by covered entity. If business associate receives a request from an individual to amend protected health information, business associate shall forward such request to covered entity within ten (10) business days. Covered entity shall be solely responsible for determining whether to amend any protected health information with respect to each request by an individual for access to protected health information;
- (g) Maintain and make available the information required to provide an accounting of disclosures to the covered entities necessary to satisfy covered entity's obligations under 45 CFR 164.528. Business associate shall cooperate with covered entity to fulfill all requests by individuals for access to an accounting of disclosures that are approved by covered entity. If business associate receives a request from an individual for an accounting of disclosures, business associate shall immediately forward such request to covered entity. Covered entity shall be solely responsible for determining whether to release any account of disclosures;
- (h) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and
- (i) Make its internal practices, books, and records available to the covered entity and / or the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

3. Permitted Uses and Disclosures by Business Associate

- (a) Except as otherwise limited by this Agreement, Business Associate may make any uses and disclosures of Protected Health Information necessary to perform its services to Covered Entity and otherwise meet its obligations under this Agreement, if such use or disclosure would not violate the Privacy Rule if done by the covered entity. All other uses or disclosure by Business Associate not authorized by this Agreement or by specific instruction of Covered Entity are prohibited.
- (b) The business associate is authorized to use protected health information if the business associate de-identifies the information in accordance with 45 CFR 164.514(a)-(c). In order to de-identify any information, Business Associate must remove all information identifying the individual including, but not limited to, the following: names, geographic subdivisions smaller than a state, all dates related to an individual, all ages over the age of 89 (except such ages may be aggregated into a single category of age 90 or older, telephone numbers, fax numbers, electronic mail (email) addresses, medical record numbers, account numbers, certificate/ license numbers, vehicle identifiers and serial numbers (including license plate numbers, device identifiers and serial numbers, web universal resource locators (URLs), internet protocol (IP) address number, biometric identifiers (including finger and voice prints), full face photographic images (and any comparable images), any other unique identifying number, and any other characteristic or code.
- (c) Business associate may use or disclose protected health information as required by law.
- (d) Business associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity's minimum necessary policies and procedures.
- (e) Business associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity except for the specific uses and disclosures set forth in (f) and (g).
- (f) Business associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law.
- (g) Business associate may provide data aggregation services relating to the health care operations of the covered entity.

4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

- (a) Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.
- (b) Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.
- (c) Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

5. Term and Termination

- (a) Term. The Term of this Agreement shall be effective as of and shall terminate on the dates set forth in the primary Agreement this Business Associate Agreement is attached to or on the date the primary Agreement terminates, whichever is sooner.

(b) Termination for Cause. Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement.

(c) Obligations of Business Associate Upon Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this agreement for any reason, business associate shall return or destroy all protected health information received from, or created or received by business associate on behalf of covered entity. This provision shall apply to protected health information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
2. In the event that business associate determines that returning or destroying the protected health information is infeasible, business associate shall provide to covered entity, within ten (10) business days, notification of the conditions that make return or destruction infeasible. Upon such determination, business associate shall extend the protections of this agreement to such protected health information and limit further uses and disclosures of such protected health information to those purposes that make the return or destruction infeasible, for so long as business associate maintains such protected health information.

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

6. Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

(d) Conflicts. In the event of a conflict in between the terms of this Business Associate Agreement and the Agreement to which it is attached, the terms of this Business Associate Agreement shall prevail to the extent such an interpretation ensures compliance with the HIPAA Rules.

Attachment D

Type of Service	Hourly Rate	Quantity of Services	Personnel Assigned with Hourly Rate
MU Audits			
Travel Expenses (Optional)			
Other Services (Please indicate if these are optional for the Other Services)			
Implementation Advanced Planning Document- Guidance			
State Medicaid Health Information Technology Plan- Guidance			
Other			
Total Costs			